DOCUMENT RESUME

ED 075 747 CG 007 988

TITLE	Mental Health and Learning: When Community Mental Health Centers and School Systems Collaborate.
INSTITUTION	National Inst. of Mental Health, Rockville, Md.; Office of Education (DHEW), Washington, D.C.
REPORT NO	DHEW-HSM-72-9146
PUB DATE	72
NOTE	69p.
AVAILABLE FROM	Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (Stock number 1724-0250, $1.25)
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	Child Development; Community Agencies (Public); *Community Health Services; Community Resources; Crisis Therapy; Disadvantaged Youth; Learning; *Learning Difficulties; *Mental Health Programs; *School Community Programs; *Schools

ABSTRACT

This book suggests the collaboration of community mental health centers with school systems since both are concerned with the healthy development of children's emotional lives and with learning. While school collaboration provides maximum opportunity for the center to fulfill more of its obligations to children with the most efficient use of manpower and funds, the book urges new forms of intervention with goals and objectives jointly determined and clearly stated. It further recognizes problems inherent in both systems that make collaboration difficult and the required precise strategies and methods of organization. The book closes with several examples of collaborative programs. (Author/LAA)

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MENTAL HEALTH AND LEARNING

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when community mental health centers and school systems collaborate

CG 007 988

A Joint Publication of the U.S. Office of Education and the National Institute of Mental Health

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When Community Mental Health Centers and School Systems Collaborate

**A Joint Publication of the
U.S. Office of Education's
Office for Nutrition and Health Programs
and the
National Institute of Mental Health's
Division of Mental Health Service Programs**

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Services and Mental Health Administration

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

Publication No. (HSM) 72-9146
Printed 1972

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402—Price $1.25

Stock Number 1724–0250

FOREWORD

This publication was prepared under joint sponsorship of the U.S. Office of Education and the National Institute of Mental Health. It was developed out of recognition that these two Federal agencies share a common concern for the optimal intellectual and emotional development of the Nation's children.

During the past decade, a number of major education and mental health programs have been enacted into law. One of these resulted in the creation of programs for handicapped children (Title VI, ESEA); another in the development of school-sponsored programs for the economically disadvantaged (Title I, ESEA); and another in the development of community based mental health centers (CMHC Act). It is the belief of OE and NIMH that programs such as these offer exceptional opportunities for collaboration between education and mental health professionals in prevention and treatment of emotional and learning disorders in school children. The specific focus of the present publication, representing one of the several collaborative efforts now underway, is on ways and means to utilize the two latter legislative programs to encourage and support the development of collaborative school mental health programs.

The Title I, ESEA educational program (Public Law 89–10) is designed to meet the needs of disadvantaged children whose learning efforts have been held back by poverty and its attendant deprivations. The program serves approximately eight million American children. It is active in over 17,000 of the Nation's school districts. The Elementary and Secondary Education Act encourages Title I program planners to cooperate with various community agencies which can provide support services. These include health and mental health services for children in Title I programs.

The Community Mental Health Centers program (Public Laws 88–164 *et sequellae)* is designed to provide a network of readily accessible mental health facilities. These are located on a neighborhood basis in communities throughout the Nation. Services are offered to catchment populations with a range of 75,000 to 200,000 persons. Over 400 such centers are now funded. A community mental health center, by definition and by mandate, can and should collaborate with schools to help school faculties, the children, and the parents in more effective ways than those available from traditional psychiatric facilities. This help from centers is particularly possible now in light of the concepts of comprehensiveness of service, outreach, and the centers' emphasis on mental health maintenance and prevention.

Traditional mental health facilities have had little influence upon and minimal contacts with school programs and problems. Schools, discovering that mental health facilities have long waiting lists, have frequently found them unable to provide crisis intervention services when they are most needed. Mental health facilities, encountering sometimes impenetrable

school organization systems, have, in turn, been impeded in their efforts to help serve the needs of children with emotional and behavioral problems. In many instances, schools have used psychiatric hospitals and child guidance clinics as referral sources for children who are disturbed or, in some cases, "disturbing" to teachers and school administrators.

The establishment of the Community Mental Health Centers Program provides an opportunity for both schools and centers to assume greater responsibility in developing new approaches and strategies to reduce children's mental health problems and to maximize their learning abilities.

It is hoped that this publication—a report on several successful, collaborative school mental health programs—will stimulate communication between mental health and education professionals and provide helpful information to school systems, centers, and communities which are considering establishment of such programs.

Sidney P. Marland, Jr.
U.S. COMMISSIONER OF EDUCATION

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EDITORS' ACKNOWLEDGEMENTS

Approximately 300 operational community mental health centers have targeted the schools within their catchment areas as the primary recipient for indirect services, such as mental health consultation and education. The extent and range of such indirect services have been modest, however, averaging only 6.6 percent of total CMHC staff time. Furthermore, the bulk of the community mental health center consultation services to schools has been for diagnostic, evaluative, and other case-by-case types of service rather than involvement along a broader front of preventive services, such as teacher training and program types of consultation. Clearly, there is need for more collaborative efforts between CMHC's and schools. This document focuses on the potential for and the mutual benefits of increased collaboration by spotlighting the pioneering efforts of five CMHC's in developing school-based mental health programs. These five were selected for presentation because of their diversity of programs and settings, their wide range of strategies, and their extensive investment in the preventive aspects of school mental health.

The five contributing authors in Part B describe their respective programs and discuss many of the problems and issues which confronted them in the course of developing them. They are in order of their presentations:

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Part A, and Chapter II in particular, was drawn from the contributions of the five authors and in a major way from Dr. Tarail's report. Their sustained interest has been invaluable in assisting and advising the editors.

Many other CMHC-school mental health programs have innovative aspects and could have been included in this publication. A listing of CMHC's collaborating in such programs—along with a brief description of the projects—can be found in Appendix I.

Mr. Ralph Littlestone, Office of Program Planning and Evaluation, NIMH, Dr. Saul Feldman, Associate Director of the Division of Mental Health Service Programs, NIMH and Mrs. Patricia Stevenson, former chief, Office of Health and Nutrition Services, U.S.O.E. have given constant guidance and support to the editors of this joint project. Helpful suggestions were also received from other staff members in both the Office of Education and the National Institute of Mental Health. The five contributing authors also wish to express their indebtedness to the many persons working with them on their respective projects whose contributions made these programs a reality (see Appendix III).

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PART A

Mental Health and Education as Natural Partners

PART A: CHAPTER ONE

THE NEED

Needed: School-Based Mental Health Programs
Advantages of Collaboration to the Schools
Advantages of Collaboration to the Centers

NEEDED: SCHOOL-BASED MENTAL HEALTH PROGRAMS

Professionals in the fields of mental health and education are concerned with the same process —the healthy development of children both in their emotional lives and in the learning process.

The close connection between mental health and learning ability is well known and has been documented in many studies. The impact of education on personality, and of emotional states on education, whether positive or negative, is extensive. We cannot productively separate the acquisition of knowledge and other products of school experience from the emotional, social, and physical development of the individual child.

The prevalence of the need to fulfill deficient mental health requirements of many school children is distressingly apparent. Police records reflect these needs as they are displayed in drug use and delinquency. Teachers and administrators increasingly voice their harassment by hyperactive and underachieving children in the classroom. Many have deserted education as a profession because of intolerable frustrations. Even more distressing is the needed attention professionals are unable to give to prevention and help for countless numbers of children who may not visibly suffer from any serious psychological problems, but who nevertheless fall short of their developmental and learning potentials.

The Report of the Joint Commission on the Mental Health of Children indicates that care is being given to only one-third of those children who are in need. It points out, further, that the present utilization of trained and skilled mental health professionals is insufficient to cope with all of society's current needs for services. Clinics, treatment centers, and other facilities often have long waiting lists. Crisis intervention for children is followed by long delays before adequate referral, diagnosis, and effective treatment can even begin. Existing resources are frequently not utilized because of fragmentation, faulty followup, or lack of communication.

Children of low socioeconomic status, particularly those in Title I schools, suffer most severely from inadequate resources and services. The social and economic deprivation characteristic of rural poverty and of urban slum or ghetto life, with its consequent biological and psychological disorders, often results in misbehavior problems. These problems interfere with learning, and result in, or become learning disabilities which in turn produce emotional distress in a large proportion of these children.

In our schools, the *extent* of school maladaptation problems, the dearth of professional resources, and the inadequate attention to prevention, combine to make glaringly evident the need for new patterns of intervention. These new patterns are necessary to increase the opportunities for optimum mental health among our Nation's schoolchildren.

Realistic appraisal suggests these new patterns for intervention in school mental health problems take form within the schools themselves, and in close collaboration with educators.

A number of intervention programs developed over the past decade suggest that school collaboration can be a successful mechanism to promote child and community mental health. The school's potential for significant preventive measures and early detection of problems is enormous. Mental health personnel who are able to promote a positive climate within the school and classroom—one in which each child is able to learn and grow to the fullest extent of his potential — can accomplish more in mental health terms than would be possible by remediation at a later date. In this context mental health consultation and training for the education system become not just minor services of

community mental health centers, but a major means of both treating and preventing psychological problems.

Schools are the main institutions with a sustained influence over children during their vital formative years.

The schools day by day deal with many times more emotional and behavioral disturbances in children than do CMHC's. They are, because of their daily influence upon the children, strategic agencies for primary prevention in mental health. The task of education is to deal with the total child—his emotional as well as intellectual development. It is doubtful that any other agency can so effectively serve this end.

The ratio of children to teachers is about 26 to 1, in contrast to ratios of 3,660 children to each psychiatrist, 2,300 to each psychologist, and 1,050 to each social worker. It is estimated that mental health clinics are seeing 1 out of 14 disturbed children, while school systems are dealing with almost 14 out of 14.

Teachers and school administrators, whether or not their training has prepared them for that role, are and will remain primary mental health agents in the lives of children. Teachers have daily opportunities to help children develop the self discipline, skill in human relations, self confidence and esteem, and abilities to work and play creatively which, in sum, contribute to mental health.

ADVANTAGES OF COLLABORATION TO THE SCHOOLS

TEACHERS

The mental health specialist can help classroom teachers better understand human behavior and child growth and development, thus enabling the teachers to develop their own skills in dealing effectively with children. The teachers then would be better equipped to assist children, not only through serious problems, but more importantly, through such "normal" crisis situations as the first day of school, separation, failure, embarrassing situations, etc. In so doing, teachers can transform the crisis situation into a healthy growth experience for the child rather than into the beginning of more serious emotional problems.

Teachers generally accept the fact that in almost all classes, a certain number of children present either behavioral or educational problems that are especially difficult to deal with. Many teachers have developed strategies to deal with these problems. However, when that repertoire is exhausted without positive result, the situation is often seen as a failure. The availability of quick intervention and consultation provided by a collaborative program reduces the incidence of these perceived failures. Moreover, the skills and insights acquired by the teacher in the process are carried over with benefit both to the teacher herself and to the entire class.

Too often, in the past, the entrance of mental health personnel into the schools has been perceived by teachers as an intrusion, a threat, an added burden, or an onslaught of judgmental criticism. Well-planned collaborative programs can change these perceptions. Clarity of role definition, the involvement of the teacher in program planning, care to avoid authoritarian attitudes, and demonstrated genuine interest in teacher problems by mental health specialists do, in time, elicit trust and increase possibilities for cooperative effort.

Prompt intervention and conference consultation can increase the teacher's awareness that some children's problems are not easily modified, and that her self-expectations may be too high. The process also demonstrates that the learning experience itself can be therapeutic for the child; that his methods of relating to adults can slowly be altered by effective teacher-child interactions.

Finally, opportunity for *prevention* of emotional or learning disability is offered by successful collaboration. The classroom teacher developing her own child appreciation and management skills through collaborative programs is more alert to early signs of distress or beginning disability. Children in her classroom will benefit from this detection and prompt followup service the programs can offer.

GUIDANCE AND SPECIAL SERVICES PERSONNEL

Auxiliary personnel, such as guidance counselors, school psychologists, and crisis resource teachers, work within the school setting and

provide support service to faculty and children. Collaboration with members of a CMHC staff can frequently help these persons increase their own skills in such areas as human relations, group processes and techniques, counseling leadership, and interviewing. They can also serve as effective liaison agents between center and schools, and as training resources for center staff members learning about the school.

PRINCIPALS

The necessity for receiving sanction in the schools for collaborative programs involves the school administration from the very beginning. The most enthusiastic cooperation of teachers and mental health specialists can have little success without the interested support of the school administration. The planning of programs with full and equal participation of school principals allays fears of executive invasion or usurpation of authority. It also gives assurance of the truly collaborative nature of the endeavor, and insures, in most cases, the essential commitment necessary for success.

In the past there have been few arenas for the consideration of problems which directly concern school principals—organizational problems within the school system, intrafaculty conflicts, faculty-administration misunderstandings, lack of time for classroom observation, or attention to difficulties which minimize effective functioning in the classroom and in the school as a whole. These are some problems for which mental health personnel can provide help.

Special seminars for principals and their inclusion in training and consultation sessions involving many levels of school personnel provide opportunities for growth in the understanding of mental health concepts as they relate to issues of school administration.

STUDENTS

Children are the beneficiaries of good mental health approaches and the victims of poor ones.

The hyperactive, acting-out, delinquent, underachieving, withdrawn, handicapped, and truant child present a wide spectrum of problems to the school. A typical reaction has been to refer these children elsewhere when possible, removing them from the classroom in an attempt to prevent their disturbing or hindering others. This solution often stigmatizes the children, engenders failure judgments in them, and causes their parents and teachers to lower their expectations of them.

The services of collaborative school-mental health programs can frequently keep these children in the school and afloat in the mainstream of education. School personnel, through training, consultation, and overt support from mental health specialists, can learn skills and approaches enabling them to cope with problem situations as they arise and before they become deeply entrenched

In the process of this multi-faceted approach, it is often discovered that when a child appears to be a problem to the school, it is because the school presents a serious problem to the child.

The school itself may contribute to a child's problems. An emotional climate that is unduly authoritarian or punitive, or one which reinforces a student's failures rather than his achievements, adversely affects his mental health. Such school environments may be altered by the collaborative process, with resultant benefit to the entire school.

School systems and schools within a system vary greatly. Such variations can result in widely differing levels of cultural and educational opportunity for children. Mental health programs can help focus administration and community attention on such problems and inequalities. Using training and consultation programs, seminars and discussion groups, mental health personnel can present concepts to faculty, administration, school directors and PTAs that may change their attitudes and approaches.

Programs for parents developed through collaboration with a mental health center serve to involve parents in school activities and to stimulate their overall interest in education. The use of local volunteers in many of the programs increases community knowledge regarding its schools and encourages closer communication between school personnel and the community as a whole.

An instance of outstanding benefit to the schools from an active collaborative program is the service such a program can deliver at a time of community crisis. In one such crisis, de-

scribed more fully in Part B, Chapter III, a school-mental health program mobilized its existing projects and community consultants to instruct, mediate, consult, and provide forums for adults and children caught up in a desegregation conflict. This mediation helped to quiet a situation which might otherwise have erupted into destructive disorder.

ADVANTAGES OF COLLABORATION TO THE CENTER

It is to the advantage of the center to combine the specialized behavior skills of its staff with the service delivery pervasiveness of the education system.

The technology of this combination calls first for the realization by mental health professionals that public schools, particularly the elementary schools, form a key front a line in the struggle to create optimum conditions for mental health in children.

The intention of mental health professionals working in school collaborative programs is not to make psychotherapists of school personnel. In these programs, mental health specialists attempt to impart their knowledge of child mental health principles and practices to school personnel through training, consultations and demonstrations, and associated techniques. Whenever possible, the programs take place within the schools, in a climate of activity in which the problems, successes, and failures may be seen more clearly than they could be seen in the atmosphere of abstract discussion in a lecture situation. The responsibility of the mental health specialist is to build upon and fully employ the skills already possessed by educators, to channel and reinforce them, and to give assurance and support which will increase their efficiency in classroom performance and personal satisfaction.

The CMHC places emphasis on prevention of mental illness as well as on provision of direct treatment services. In the light of staff shortages and demand for direct services, prevention poses a gigantic problem to the center. This is especially so when serving catchment areas of widely separated settlements or of densely clotted populations with fragmented community resources. Prevention of mental illness and maintenance of mental health in a community presupposes attention to its children. The environment in which growth and learning are encouraged or discouraged is the environment which determines their mental health. *School collaboration, therefore, provides maximum opportunity for the center to fulfill more of its obligations to children with the most efficient use of manpower and funds.*

The school system is a vehicle through which the center can reach the majority of children, their families, and the school personnel who are important influences in their development. Collaboration with the school system brings vast numbers within the scope of the center's services. Within these numbers are the targets for preventive and maintenance services as well as those displaying symptoms of beginning or entrenched learning and emotional disorders.

Designing and planning collaborative programs also brings into the center's sphere of operation many community resources and agencies which might otherwise contribute much less to the field of mental health. The success some CMHCs have had in establishing and maintaining effective consultative linkages for referral and monitoring among welfare and family agencies, juvenile courts, and voluntary child serving agencies is an example of this.

The implementation of collaborative programs with the schools allows the center to multiply by many times the mental health education efforts of its existing staff. School programs also contribute significantly to assessment of the community's mental health needs, to development of new resources, and testing new service delivery systems, with consequent opportunities for program evaluation and research.

PART A: CHAPTER TWO

PLANNING

Planning a Collaborative Program
Goals
Problems
Strategies

PLANNING A COLLABORATIVE SCHOOL MENTAL HEALTH PROGRAM*

The various programs discussed in Part B, although they differ as to location and evolution, agree that: goals and objectives must be jointly determined by the mental health center and the school and must be overtly and clearly stated; problems exist in both systems which may make the collaboration difficult; principles, strategies, and methods of organization can help overcome these difficulties.

GOALS AND OBJECTIVES

Each collaborative program, because of its particular setting, needs, special interests, funding, and community character, has its own individual list of stated goals. As the programs develop, there may be a modification of emphasis in response to changing climates or the emergence of new problems. In general, however, the primary goals are:

- To prevent emotional and learning disorders in school children through the early detection of behavior and learning difficulties;
- To influence the development of school environments and mental health attitudes which are conducive to the optimum realization of learning ability and sound mental health in children;
- To increase in-service educational opportunities for both education and mental health professionals; i.e., to provide training and consultation in mental health principles and practices to school personnel, and enlightenment regarding school system problems and practices to mental health personnel.

PROBLEMS IN DEVELOPMENT AND ORGANIZATION

There are problems inherent in both the current educational system and the current mental health center system. These tend to make joint collaboration difficult and to minimize its effectiveness and success.

PROBLEMS WITHIN THE SCHOOL SYSTEM

A frequent lack of orientation to the mental health needs of children by school administrators and classroom teachers. Serious questions have been raised by educators and mental health workers about the absence of adequate training and preparation of school personnel regarding child mental health. Many teachers lack opportunities for in-service training in principles of child development or in preparation for understanding and dealing with a wide range of behavior in the classroom.

Lack of awareness by school teachers and principals of the help and services a center can provide. Many teachers and administrators in Title I, ESEA schools have expressed their frustration and their sense of being overwhelmed by the prevalence of misbehavior and learning problems among Title I children. Mental health personnel, with their expertise in human behavior management, can provide support and consultation not only to help the teacher deal with crisis situations, but also to cope with everyday classroom problems and to work more effectively with children.

Fear of criticism by outsiders on the part of school personnel. Many teachers who are already overburdened may feel that involvement in programs will bring about criticism of their teaching abilities, cause lost free time, or demand lengthy record-keeping for supervisors. Principals may feel that mental health personnel in the school would undermine their authority. Resistance or suspicion may show them-

**Dr. Mark Tarail made a major contribution to the development of this chapter.*

selves in passive form, such as the forgetting of meetings, or the insistence that problems of time and space make the programs unfeasible.

The medical suspension syndrome. For many teachers and school administrators, the solution for a child with serious behavior problems alleged to be disturbing to the classroom is "get rid of the kid." A typical way of achieving this extrusion of the child from the system is to obtain a medical suspension from a physician or psychiatric facility.

The dumping syndrome. There is a tendency for some administrators and teachers to consider children who are *disturbing* to the internal system in school as *disturbed.* School personnel, in this connection, tend to look for a psychiatric facility upon which to dump the problem, rather than to serve the difficult child's needs within the school system. This dumping "solves" the problem for the school but not for the child; and further, it avoids facing the need for change within the system.

School system bureaucratic "hang-ups." Many internal organizational problems and conflicts within the school system act to minimize or prevent effective mental health approaches and services to children with problems.

Two examples will serve to illustrate the problem:

a. Conflict and competition exists, in some areas, among special units within the school system established to provide mental health and related services to school children (child guidance, psychological services, attendance, etc.).
b. School mental health services often cover some, but not all, mental health needs in the school system. Special units and bureaus are often severely handicapped by inadequate budgets and lack of staff.

Fear by school mental health personnel of outside interference. Collaboration with a community mental health facility often is perceived by school mental health personnel as a threat to themselves and to their own system of services. They may wish to utilize the outside facility for referrals, but hesitate to establish collaboration. This sense of competition and threat sometimes is reinforced by dominance-seeking community psychiatric facilities.

Restrictions regarding treatment imposed upon school mental health services. An example of this problem is the prohibition placed on school psychiatrists and other medical personnel in providing medication during treatment in some school systems.

Overemphasis on diagnostic services. In some schools, mental health services are purely diagnostic with treatment provided elsewhere. Also, diagnosis and treatment in some school mental health services are tradition-oriented rather than preventive and community-oriented.

Conflicting perceptions of roles. In many instances the school personnel's perceptions of the role of the center in giving help may be quite different from the center's own perception of its role and methods. For instance, the school may see the center as a place of referral. The center, on the other hand, may see itself as an advocate for the child and may wish to influence the school to keep the child in the school setting.

Polarization. In many local communities and especially in ghetto areas, a sharp polarization has developed in recent years between school faculty and parents, and between school faculty and children, regarding the nature and control of the public schools. This conflict of demands and perceptions of needs is a serious problem in the development and organization of school-center collaboration.

Inadequate community planning. The frequent lack of effective citywide and local community planning between health agencies and school systems represents a serious problem which interferes with effective collaboration between local schools and a local CMHC. Each tends to plan without joint consultation and involvement —sometimes without regard to each other's needs, mandates, and problems—and often without regard to priorities based on needs of the children.

PROBLEMS WITHIN THE COMMUNITY MENTAL HEALTH CENTER SYSTEM

Down-grading and intolerant attitudes of mental health professionals toward school personnel. These attitudes frequently exist in center personnel and tend to be projected in such a way as to build in failure to the collaborative programs.

Lack of knowledge of the learning needs of children and of the realities of the school environment by child mental health personnel. The historic fragmentation of human services in this country frequently has produced a fragmentation of knowledge by specialties. Mental health professionals may perceive only fragmented and partial needs of a child instead of the total needs of the whole child. Furthermore, center staff members generally have had little experience and training in relation to educational processes or school systems.

Inability of mental health personnel to communicate effectively with educators. Many mental health workers use alienating jargon and submit reports in clinical, technical language with recommendations that cannot be realistically carried out in the existing school setting.

Traditional separation and conflict between specialists. Child psychiatry is often alienated from adult or family psychiatry. Conflict and lack of understanding often exist among psychiatrists, educational psychologists, and educators.

Lack of knowledge by therapists about educational treatment modalities. Clinical personnel may be unfamiliar with learning theories or with learning disabilities and their treatment. Training schools for professionals in all of the mental health disciplines rarely expose the workers to this area of knowledge.

Lack of appropriate consultation and community organization training. The need for retraining mental health personnel on an inservice basis in all disciplines is vital if they are to be effective in the consultation processes and in the use of community organization approaches required in a successful school-center collaboration.

Intraorganizational problems. Organizational problems and lack of effective systems within the center regarding intake, referral, and follow-up procedures may tend to minimize the center's ability to provide quick and effective treatment to children referred by the schools.

Whose patient is the child? Whose responsibility? There sometimes is a tendency by the mental health center to act as if the child is the responsibility of the school and not of the center. While school and center argue or abstain from accepting responsibility, the needs of the child can be neglected. Parents and child react, as a result, with frustration and disillusionment with both facilities.

A policy problem. An important policy question must be resolved within the center if collaboration is to succeed: If the mental health needs of children are not being served effectively in a school, to what extent should the center serve these needs within its own framework, or to what extent should the center push responsibility for such programs back on the schools, while helping the school system to become more effective in providing for such needs?

Polarization. As mentioned earlier, certain areas of the country are plagued with local community-school conflict centering around issues of community control. The center is faced with often contradictory and conflicting demands for support from school personnel, parents, and children. How does the center integrate concurrent work with a school faculty which resists change, work with parents trying to change the school system, and work with children who often are anti-school faculty and sometimes anti-parent?

Intracenter organizational coordination. How should the center organize and integrate the various units and elements of service which may tend to work independently in the schools and with school children? The more complex the CMHC organization, the more difficult is the problem. For example, in such cooperating units as: the Learning Rehabilitation Service Units, the Child Psychiatry Outpatient Clinics, community prevention programs administered by community organizers, General Service Storefront Programs, Family Therapy Units, Mental Retardation Clinics, General Hospital Outpatient Pediatric Clinics, Community Parent Educational Programs, etc. Mechanisms which assure overall unified direction, coordination, and monitoring will need to be carefully worked through to insure the effectiveness, coherence and credibility of the CMHC's overall collaborative effort in a school mental health program.

STRATEGIES AND METHODS OF ORGANIZATION

Some principles and strategies which have evolved out of the experiences of centers in relation to the organization and development of collaborative programs with the schools are the following:

INTEGRATE PERCEPTIONS OF NEEDS

Since major obstacles to successful collaboration can arise from varying perceptions of needs and roles, it is essential to clarify these perceptions and integrate them in program planing. Some approaches found helpful follow.

- Explore and identify perceptions of mental health needs of all groups involved or concerned, namely: administrators, faculty, special school personnel, other facilities personnel, children, parents, and center staff.
- Once these different perceptions are identified and made overt, the center can play a mediating, bridging, and coordinating role regarding the differences. The center should organize face to face meetings with the various groups to confront directly their different perceptions.
- The center should take responsibility for integrating and organizing services around an objective concern for the needs of children untainted by school or mental health organizational needs.
- Many of the differences represent not only differing *perceptions* of need, but different *actual* needs. The program planners should attempt to identify these needs and establish services aimed at accommodating the various groups involved in the collaboration.

ASSIGNMENT DECISIONS

Selection of programs and areas of concentration should be made by school personnel in consultation with center staff. This approach tends to minimize the threat to school personnel, maximize school involvement, and effectively utilize the greater knowledge of school problems possessed by school faculty.

A helpful organizational device is to ask the official leader of the local schools, such as the district superintendent, to establish a catchment area-wide Community Mental Health Center Liaison Committee of school personnel to work with the center. The membership of the Liaison Committee should be appointed by the district superintendent. An effective committee may be comprised of the superintendent, principals of all schools within the catchment area, representative teachers, and representatives of various mental health related units within the school system.

POLICY OF SUPPLEMENTATION

The CMHC must state and implement, openly and continuously, a policy of supplementing, not supplanting, school mental health services and programs. It is helpful if the center makes known its availability to the schools for consultation and training and plays a support role in helping schools to fulfill their responsibilities in this area.

BUILD TIME, AS AN ENTITY, INTO THE PROGRAM

When two groups of professionals with different orientations, vocabularies, and understandings begin working together, there is bound to be some degree of conflict and misunderstanding. Time, as an entity, must be built into the program to permit professionals in both disciplines to learn to understand one another and to have a real meeting of minds.

DEFINE ROLES AND RESPONSIBILITIES

The roles of the various professionals involved in the program should be well defined and understood by all. In addition, it should be made expressly clear to classroom teachers that the mental health personnel involved in the program have *no responsibility* whatsoever for supervising, evaluating, or rating teachers.

INDIVIDUALIZING PROGRAMS

Collaborative programs should be individualized for specific schools, taking into account: ages of children; the demography, epidemiology, and ecology of each neighborhood within the catchment area; the readiness of school faculty for such collaboration; the needs of the specific pupils; and the needs and organization of the special mental health bureaus within each school.

CONSULTATION PROCESS

The traditional consultation process must be redefined to develop effective collaboration. Traditional consultation in the health field has been limited to a diagnostic and advisory role by one professional to another professional. The consultant traditionally is not responsible for the client or for carrying out his recommendations.

Consultation in these collaborative programs is quite different. It is characterized by the mental health consultant's involvement in the provision of service and by the physical presence of mental health personnel on the premises of the school for specific periods of time on a planned basis. A consultation process which confirms the diagnosis of an emotional disorder in a child and limits itself to a recommendation for psychological treatment without providing followup for the treatment is a self-defeating and frustrating program for school personnel and especially for the child and his family.

SERVICE BACKUP

It is helpful when consultation and learning programs are backed up by diagnostic and treatment services. With such backup, programs in the schools have a better chance of serving the mental health needs of the children and personnel.

TRAINING FOR CENTER STAFF

Formal programs of specialized training and supervision must be instituted by the center for its own staff who are assigned to work with the schools. Child psychiatrists, psychologists, clinicians, special learning rehabilitation service workers, and others on the center staff would be the recipients of this training. Experience has shown that mental health personnel have a very limited knowledge regarding school systems and their functioning. A knowledge of school problems, an understanding of teacher frustrations and anxieties, and respectful appreciation of their achievements are as necessary to a succesful program as concern for the children.

It is helpful if personnel from the collaborating schools can be involved in training the mental health staff. This school involvement provides a comfortable and significant channel through which important knowledge of school needs and systems can be communicated to the mental health staff. Such involvement often results in greater commitment of school personnel to the programs. School participation also serves to project an essential concept of peer relations between school and mental health professionals.

INDIGENOUS PARAPROFESSIONALS

The use of local paraprofessionals on a volunteer and paid basis in the collaborative programs can be one of the most important keys to their success. The compelling conviction is that human qualities such as commitment, devotion, interest, empathy, and enthusiasm can serve distressed children as well as the traditionally revered qualifications of formal degrees and education. Mental health personnel in collaborative programs can liberate and reinforce these human qualities by training, consultation, supervision, and support; in turn, they can benefit from the paraprofessional's intimate knowledge of the community. Maximum effectiveness is achieved when education and mental health professionals can accept and work with nonprofessionals as complementary and supplementary partners on a peer level.

POLARIZATION AND COMMUNITY CONTROL

The sharp conflicts involving issues of community participation and control of schools and centers cannot be ignored by either in a collaborative program. Efforts can be made to turn the conflict into coalition and partnership between the often hostile parties. Realistic, open confrontation of these issues by both centers and schools has been found to be helpful. School personnel have sometimes played a mediating role in community relations where problems exist between the center staff and consumers in a local community. On the other hand, center staff often have played a mediating role in dealing with problems between school personnel, children, and parents. It should be emphasized that the issues of community control and consumer participation in service institutions are as pressing on many centers as they are on schools.

STRATEGY OF CONCENTRATION

CMHCs, while mandated to provide comprehensive services, usually have limited budget and manpower resources to devote to school collaborative programs. It therefore becomes imperative to develop a strategy of priority and concentration. One center approached the problem as follows:

- A selective plan was developed for concentration on Title I schools which involved provision of maximum services in these schools and fewer services to other schools, if it became necessary. The guiding principle was to serve where the needs were greatest.
- Points of concentration and policies involving priorities were worked out with representatives of the schools.
- The center took responsibility for obtaining special funding for the school collaboration programs from various funding sources in Federal, State, and county governments.
- Points of concentration were changed from year to year and involved different strategies and priorities for different elements of the overall collaborative program.

WORKING WITH POWER—A STRATEGY OF IMPLEMENTATION

Experience demonstrates the importance and validity of working concurrently with all levels in the educational hierarchy: the higher (boards of education and superintendents), the middle (principals, supervisors, and special bureau heads), and lower (classroom teachers, guidance counselors, special bureau personnel). Working exclusively with the power-on-top or with the school faculty will lessen the chances for success in the program.

The greater the extent to which center staff are able to be genuinely helpful to school personnel in helping them with problems as *they* perceive them, the greater will be the demand by these school persons for continuation of the program.

Also, as each element of a collaborative program becomes useful to a particular group, that group tends to press the appropriate level of personnel above and below in the bureaucratic hierarchy to become more actively involved in the collaboration.

INTEGRATION OF LEARNING REMEDIATION, AND THERAPY

Implied in a collaborative program between a mental health center and a school is the principle of integration of the learning needs, the remediation needs, and the therapeutic needs of the child. Traditionally, in both the school and mental health systems, these needs have been perceived as separate and treated in a fragmented way. Experience has demonstrated that children who have learning difficulties frequently have, or develop, emotional problems and poor self-concepts. Simultaneous treatment of the learning and emotional problems achieves the best results for the child.

In general, the above principles and strategies have been found through experience to be helpful in the organization of collaborative programs between schools and CMHC's. Centers and schools which have attempted to develop such programs have often found the problems involved in the collaboration to be difficult and complex, but the results both rewarding and effective.

PART B

Examples of Collaborative Programs

PART B: CHAPTER ONE

URBAN Setting

Maimonides Community Mental Health Center, Brooklyn, N.Y.
Primary Mental Health Project, Rochester, N.Y.

THE MAIMONIDES MENTAL HEALTH CENTER COLLABORATION WITH TITLE I SCHOOLS

Brookiyn, N.Y., Mark Tarail, Ph.D.

SETTING

The Community Mental Health Center of Maimonides Medical Center in Brooklyn, New York, serves a population of about 130,000 in a congested urban area. The people are mainly poor working class, with many living at or below the poverty level. There are roughly 30 percent Puerto Rican, 30 percent Italian, 30 percent Jewish, and 10 percent other groups, with many close ethnic enclaves.

The Center's full-time staff of 10 and a large, constantly increasing number of Center-trained workers operating in or with the schools serve 15 public schools and 9 parochial schools, 6 Hebrew and 3 Catholic. The public schools number 11 elementary, 2 junior high, and 2 senior high.

All funds supporting Center-school collaboration come from the Center budget. None have come from the Board of Education or other resources. While this has somewhat hampered the extension of programs, it has placed most of the initial program direction with the Center staff.

The densely populated character of the area and the extensive and intensive character of the program result in a much closer contact with the school population and their families than is generally the rule.

HISTORY

In 1963, a full-time outpatient psychiatric clinic was established in the Department of Psychiatry in the Maimonides Medical Center, and work with a few of the neighborhood public schools was begun. In 1967, with the establishment of the Comprehensive Community Mental Health Center, the present extensive collaborative programs with schools began to grow.

Limited resources of funds and staff for the first two years were concentrated on a selected different school each year, with provision of inservice mental health training initially to guidance counselors, attendance teachers, and supervisors. The initial consultation team comprised a psychiatrist, an educational therapist and a social worker. The first inservice training seminar was organized for attendance teachers in collaboration with the system's Bureau of Attendance, followed by a seminar for Bureau supervisors.

From this beginning and concurrently with the development of the Community Mental Health Center grew the present group of collaborative programs between the Center and all public and parochial schools in the catchment area, with special concentration on Title I schools. One of the historic characteristics of this type of collaboration was that each program produces a demand for additional services and projects in snowball fashion.

One of the major ostensible disadvantages in working initially with limited staff and funds has turned out to be one of the bases for the success of the collaboration. From the beginning, limited resources forced an emphasis on the utilization of many paraprofessionals and volunteers as direct program providers. The highly trained professionals in education and mental health acted for the most part as consultants, trainers, and co-organizers of the programs. Experience has demonstrated thus far that this type of staffing approach is more effective in achieving the objectives of the collaboration than the traditional approach with

its exclusive emphasis on the provision of services by the psychiatric or educational professional.

All Maimonides programs involving collaboration with schools have had these objectives:

- To influence the development of school environments conducive to optimal mental health and learning in children.
- To prevent mental and emotional disturbances by dealing as early as possible with children's problems.
- To provide early detection, treatment, and remediation of behavior, emotional, and learning difficulties.
- To develop the mental health and interpersonal skills of teachers and other school personnel through inservice mental health training and consultation. Once learned, it is expected that educational personnel can continue to use these techniques and strategies *without* further help from the Center.

ORGANIZATIONAL MECHANISM

Experience has demonstrated that certain organizational mechanisms are helpful in implementing a collaborative program. These mechanisms are formal structures through which policy and administrative decisions may be made, and they represent channels of interaction and participation for combinations of school personnel, mental health personnel, parents, and pupils. Some of the organizational mechanisms in operation are the following:

LEARNING REHABILITATION TEAM AND CLINIC

This special unit of our Mental Health Center, acting as the spearhead and consultation unit for the collaborative school programs, is comprised of a full-time staff of educators, educational psychologists and therapists, trained paraprofessionals, and supervisors in the Center training programs. A support system of child psychiatrists and other mental health specialists supplements this staff. The Learning Rehabilitation Team administers the programs in the schools, the Center, and in neighborhood storefront service centers. They also provide a tutor-therapist recruitment and training program, a remedial reading clinic, a behavior modification clinic, a developmental diagnostic service for children with behavior problems and reading retardation, and appropriate research studies related to their field.

CHILD MENTAL HEALTH SERVICE COORDINATING COMMITTEE

Within the Mental Health Center, child services are provided by a number of different units, such as the inpatient unit, outpatient clinics, Mental Retardation Service, learning disability service, general hospital pediatric-psychiatry consultation, community and parent education, child reception service, etc. The Coordinating Committee comprises the leadership of each unit, to provide interaction and planning, implement center-wide policy, and develop strategies for the most effective use of all resources.

CHILD MENTAL HEALTH UMBRELLA

School programs operate under the general umbrella of Center Child Mental Health Services organizationally and philosophically. This approach has been found to be the least threatening to school personnel, and it establishes the necessary administrative controls for continuity of care and statistical reporting.

SCHOOL LIAISON COMMITTEE

This committee is appointed by the school administration, not the Center. It represents the school system's involvement in the policy and decisionmaking process of the collaborative program. This committee meets twice a year, in the fall and spring, to decide policy, list priorities, establish strategies, plan new programs, and evaluate those in action. Membership includes school principals, various Bureau representatives (i.e., Bureau of Attendance, Bureau of Vocational Guidance) and Mental Health Center presonnel.

COMMUNITY MENTAL HEALTH CENTER TEAM

A team of mental health and Learning Rehabilitation workers from the Center is assigned to each school for specified days and periods each week, in accordance with program plans and strategies. This team provides the personnel necessary to implement the program in each school.

SCHOOL SCREENING WORKER

The school principal and Pupil Personnel appoint one person to act as the central screening worker for that school. This person, usually a guidance counselor or child guidance worker, serves as the coordinator of services for the child and liaison agent between school and Center. This mechanism reduces the dysfunctional effect of internal bureaucratic school problems.

MENTAL HEALTH LIAISON WORKER

To serve a similar purpose within the organizational system of the Mental Health Center, one center worker is assigned as the liaison with each school. A school worker no longer calls the Center with a problem, and a Center worker no longer calls the school in the former depersonalizing and impersonal bureaucratic way. The directly named liaison workers develop personal contacts, thus avoiding delays of time or political maneuvering and moving both organizations quickly to meet needs.

CURRICULUM COMMITTEES FOR INSERVICE TRAINING

Experience has demonstrated that the most effective way of developing an inservice mental health training program for school personnel is to involve the subjects of the program together with the consultant faculty from the Mental Health Center in the determination and development of the content of curriculum. Thus, each in-service training program is planned by a joint curriculum committee of school personnel and Center workers. The Center provides expertise, consultation and faculty personnel to carry out the training. Since perceptions of needs by school and Center personnel may be different, these committees leaven and mediate. They also provide a learning experience for Center staff concerning the nature and problems of school personnel, resulting in more effective contributions to collaboration.

COMPONENTS OF THE COLLABORATIVE PROGRAM

The components of the school/mental health collaboration include a wide variety of programs, projects and activities formulated in relation to need and aimed at achieving the previously stated objectives. Each program has evaluation built into it, is subject to change as need and experience indicate modification, and is organized either on a trial and error basis or through a planned approach.

An enumeration of some of the examples of the specific programs will serve to illustrate the general model of this approach.

TRAINING PROGRAMS FOR MENTAL HEALTH PERSONNEL

Inservice training programs for mental health staff have as objectives: (a) To familiarize mental health staff with school structures, policies, and procedures; and (b) To give mental health staff an appreciation of school and children's problems as perceived by classroom teachers and school administrators.

Seminar on School Consultation Process. A seminar led by Center staff on principles, strategies, and methods of school consultation is offered once a year in four to six sessions. Participants are child psychiatrists, psychologists, educational therapists, indigenous tutor therapists, and mental health nurses. School personnel are utilized in the seminar to enhance the insights of Center personnel concerning school problems and structures.

Ongoing Supervision as an inservice training device is provided through the Learning Rehabilitation Service staff of the Center.

Mental Health Trainees are exposed to supervised experiences in the schools. These trainees are psychiatric residents, community organization trainees, social work students, and psychology interns.

Formal Inservice Training is provided to paid and volunteer Center staff in remedial reading methods, in counseling, and in individual and group therapy techniques.

Clinical Case and Incident Presentations at regular Center staff meetings and outpatient clinic staff meetings keep other Center personnel informed with regard to the nature and progress of the collaborative programs.

TRAINING PROGRAMS FOR SCHOOL PERSONNEL

Inservice training programs for educators have as objectives:

1. To increase mental health insights and skills of school personnel.
2. To help develop a mental health reinforcement environment within the school structure.
3. To help school personnel make decisions concerning children's problems in terms of the child's needs rather than organizational expediency.

The training program includes:

Principals' Mental Health Seminar. Once a month throughout the school year, school principals attend an inservice mental health training seminar. The fundamental technique is for each principal to bring in a critical administrative decision which he must make or has just made which involves the mental health of his students—i.e., should Johnny be suspended? Should Mark be placed in a special class? These critical problems or incidents are discussed by the group as a whole based on mental health criteria. The emphasis is on the mental health component of administrative school decisions.

Classroom Teacher Training is conducted in Title I schools through both formal and informal seminars and groups. Formal groups are led by Center personnel in the schools during teacher release time. Informal groups meet during lunch hours or other free time. The objective in this program is to increase the mental health insights of the classroom teacher so that she can function more effectively with all children and make more relevant decisions within ongoing classroom processes with regard to the special needs of disturbed children who may happen to be students in her class.

One of the most successful training methods has involved the assignment of an experienced child psychiatrist as a co-teacher in a classroom with one of the regular teachers.

Remedial Reading Teachers Seminars are provided yearly on new techniques of remedial reading and on the relationship between mental health problems and reading retardation. Mental Health Center personnel also work with reading teachers in the classroom.

Guidance Counselor Training Has Included:

- A borough-wide "Child Development and Mental Health Problems" Seminar for Guidance counselors and supervisors.
- Seminars in group counseling, group guidance, and family therapy.
- Seminars on methods of developmental diagnosis, testing, and treatment of disturbed children.
- In selected instances, as a training as well as service mechanism, a Mental Health Center worker and guidance counselor carry an individual child and his family together as co-therapists.

Attendance Teachers' Training, developed jointly by the Bureau of Attendance in New York City and the Center, offers seminars on approaches to administration, group therapy and counseling, family therapy, child development and psychopathology in children, and mental health analyses of school absenteeism. The emphasis is on the provision of services to truants, addressing the truancy as a mental health problem rather than a police problem.

Special Education Teachers are provided supplementary training with formal seminars and informal group experiences. Issues in Special Education that relate to mental health are discussed—i.e., the problem concerning the disproportionate number of disadvantaged, ethnic, and minority group children who are placed in classes for the mentally retarded when many might function more effectively in the regular class setting. Emphasis is given to mental health problems created by the unfortunate labeling, classifying, and stigmatizing of children segregated in special classes.

Teacher-aides and Assistants are trained in seminars led by the Learning Rehabilitation staff. Subjects include: remedial reading techniques, tutor-therapy skills, child development, and special mental health needs of disadvantaged Title I children.

TRAINING FOR PARENTS

Organized groups of parents have been trained as remedial reading counselors and tutor-therapists in the schools, in the Mental

Health Center Learning Rehabilitation Service, and in neighborhood service storefronts.

A new program trains parents to be tutor-therapists with their own children who have reading retardation or mental health problems.

Workshops, seminars, and open-ended groups for parents deal with issues of child development and effective parenthood. Many of these groups are led by parent leaders trained by professional Mental Health Center staff.

Open-ended parent counseling groups for parents of Title I school children with problems are led by Center personnel.

TRAINING FOR CHILDREN AND TEENAGERS

One of the most promising programs of the School-Center collaboration is a program designed to train children and young teenagers to serve as tutor-therapists for younger children and for their peers. It has been noted that one consequence of this process is that the tutors themselves improve substantially with regard to their own learning and emotional problems in the process of helping the children whom they tutor.

JOINT TRAINING

Conjoint training of the teaching faculty, special education and school mental health personnel, Center personnel, parents, and sometimes the children themselves has been found to produce effective results. This conjoint training occurs on occasion only and does not substitute for regular training.

SERVICE PROGRAMS

DIAGNOSTIC SERVICES

The program ties diagnostic services with the provision of consultation and treatment services to avoid the frequent problem in Title I schools of over-diagnosis and under-treatment.

The Child Mental Health Central Reception Service at the Center provides prompt diagnostic service, evaluation, crisis intervention, and short term individual and family treatment.

The Pediatric and other medical departments of the Medical Center provide physical examinations and medical treatment to children with emotional problems.

The Learning Rehabilitation Service team and the Mental Retardation Service offer diagnostic and evaluation services. They also are responsible for bringing the child and his family together with appropriate service resources in the community for followup care. Experience in the collaboration has led to a practice which emphasizes the importance of developmental diagnosis in terms of perceptual motor and cognitive abilities basic to the learning of academic skills. The objective of diagnosis is the rehabilitation of learning and behavior problems and not the mere classification of disorders.

THERAPEUTIC, EDUCATION, AND PREVENTIVE PROGRAMS

Reading and Learning Disabilities Clinic. The question might validly be posed as to why a Community Mental Health Center concerns itself with reading methodology. Experience has shown, overwhelmingly, that aggressive, disruptive, or withdrawn children referred to the Mental Health Center almost invariably have learning problems as well—especially in reading. It became evident that therapy oriented toward improving interpersonal relations would do little to enhance the low self-image of these children without simultaneously dealing with their failure in school—failure resulting largely from reading problems.

A Reading Therapy Clinic directed by a learning disabilities specialist was set up *directly* in the Mental Health Center. An approach was sought which would help the failing child learn to read and, in the process, to begin thinking of himself as a successful and worthwhile human being.

The Clinic is staffed by volunteer tutor therapists trained in reading remediation and in behavior modification techniques. An intersensory reading methodology is employed. Since training time for volunteer tutors is limited, a highly sequential series of 48 illustrated lessons of programmed material was developed which experienced tutors could use with confidence and success. The tutors can be trained in the basic techniques and application of the method in three, 1-hour training sessions.

Children are tutored in the Clinic on a one-to-one basis twice a week. The volunteer tutors include parents, teenagers, Urban Corps work-

ers, senior citizens from the Geriatric Program of the Center, and other local residents indigenous to the catchment area. These volunteers work under the direction of the trained professional and paraprofessional Mental Health Center staff.

Seen in mental health terms, the one-to-one relationship between a failing child and a caring adult with the goal of rehabilitating the child's reading is a very effective form of task-oriented therapy. It can generally have important therapeutic effects and result in substantial behavior improvement.

Outpost Diagnostic and Reading Therapy Services for dropouts are given in connection with local poverty organizations and the Neighborhood Storefront Services.

Summer Day Camp for Minimally Brain-Damaged Children, located in a poverty area, operated in the summer of 1970 with Center funds and supportive trained staff. A community coalition of local organizations set policy and administered the program. Overt success was seen in the children's increased ability to cope with school and personal social problems.

Mental Retardation Clinic, in the Department of Psychiatry of the Medical Center, is a central intake unit, a referral service, and a collaborator in programs with the schools.

A special emphasis in the Clinic's approach is to differentiate between biological retardation and retardation which is a consequence of social and economic deprivation and which afflicts a large percentage of the children in Title I schools who are labeled "retarded."

Children's Reception Service in the Center provides immediate response to school referrals, quick intake and crisis intervention, short term individual and family therapy, and evaluation. It is also a means of control over the disposition of children to other resources. The staff is a team of mental health specialists. This availability of direct services without waiting lists as a back-up to the collaborative school programs is an important factor in the growth of the programs.

Crisis Intervention takes place in the school in the Center, in the home, on the street, and wherever the children live, work, or play. Immediate intervention may come from any professional, paraprofessional, trainee or consultee, and is utilized as an initial step in providing further services.

Tutor Therapists

Parent Tutor Volunteer Reading Program, begun four years ago with 16 volunteers, now involves over 300 parent tutors. After six training sessions at the Center, tutors work with children on a one-to-one basis in some quiet corner of the school or grounds outside of the classroom. Supervision and training are provided by continuous weekly meetings with a Learning Rehabilitation staff member.

Child Tutor Therapists, recruited from the sixth and eighth grades, are trained at the Center as tutors for third graders in their own schools. Center staff provide weekly ongoing training and supervision. Since a large percentage of the pupils in two Title I schools are Puerto Rican, high school and junior high Puerto Rican students are trained to tutor younger children after school in the school or in the children's homes on a one-to-one basis.

Senior citizens over 65 are trained as tutor therapists and are among the most effective tutors in the program.

School personnel, especially kindergarten and first grade teachers, are trained in the use of the Pollack Intersensory Method as a basic instrument for teaching reading in their classes. Reinforcement to the slow children, supplementing the work of these teachers, is given by trained sixth graders.

As a pilot project in a Title I school, a kindergarten teacher was trained by mental health staff in the use of the Pollack Phonic Readiness Set to help children in her class develop the auditory perception skills necessary for reading readiness.

School Consultation—each school has an assigned Mental Health Center team working on the school premises a specific number of hours on certain days each week. A variety of consultation services are provided including the following:

- A regular weekly case conference involving teachers, guidance counselors, corrective read-

ing teachers, and Mental Health Center personnel. The school case conference discusses a particular child's learning and behavior problems as well as general school mental health problems. Experience has demonstrated that this model of communication and interaction achieves two objectives; it helps resolve a particular child's problems, and it provides an effective approach to train mental health school personnel.

- Guidance counselors and junior guidance counselors in Title I schools receive regular weekly consultation on an individual or case conference basis. The process involves evaluation of problems and recommendations for therapy.
- Principals and officials of the district superintendent's office receive ongoing consultation, both regular and as requested.

Hip Reader. Special materials have been published by the Learning Rehabilitation Service staff utilizing street hip language as a channel for reading remediation for adolescents and youth. Junior high school students in the Title I area are trained and supervised by a member of the Learning Rehabilitation Service team to teach functionally illiterate adolescents to read with the Hip Reader. A task oriented therapeutic approach involving group motivation and attitude change is employed. An after-school homework center uses specially trained peer tutors among the adolescents themselves to work with non-readers under the supervision of a school staff member.

Child Helps Child. A controlled demonstration project is operative each year. It involves utilization and training of "acting out" and reading-retarded eighth and ninth graders to tutor third and fourth grade nonreading boys on a regular basis of twice a week for a full academic year. This "child help child and both learn" practice has resulted in better reading grades and therapeutic behavior changes in both groups. The tutors and the tutoring process are supervised by members of the Learning Rehabilitation Service staff. The staff also supervises group therapy in the form of rap sessions for tutors and pupils as well as individual sessions when needed.

Neighborhood Storefront and Community Projects. The Maimonides Community Mental Health Center operates an extensive group of programs through its outreach neighborhood satellite service centers housed in storefronts (such as converted grocery or butcher shops), and through its community educational and preventive programs. These outreach activities involve close contact on a grass roots level with residents in the community. Collaborative programs have been developed between these outreach Mental Health Center Neighborhood Centers and Title I schools. Programs include:

Grass roots tutorial aid for Spanish-speaking residents. Mothers and children of a local tenement house meet weekly in one of the house apartments. Older children are trained to tutor their juniors in reading, aided and supervised by the mothers with the help of Learning Rehabilitation staff.

Preschool day care operates through two Storefront Centers. These programs operate in the area of prevention and are designed to train preschool children in the basic skills necessary for reading. Goals of the preschool program are:

- Early identification of learning problems.
- Workshops to train mothers in developing their own children's perceptual readiness skills.
- Facilitation of social action by local mothers in the establishment of a full-time day care center with funding from the City government and help from other community agencies. This effort has been successful.

Developmental evaluation and educational therapy programs for children who respond more effectively outside of the school are housed in the neighborhood storefronts.

Educational therapy with non-reading truant adolescents is also given in programs in the storefronts.

Remedial reading and educational therapy in Spanish for the Puerto Rican population. Indigenous Puerto Rican leaders, adults, and young people trained as tutor therapists have been providing remedial services, supplementing the remediation services of the Title I schools, to local Puerto Rican residents in Spanish as well as in English. Many of the teaching materials utilized by the Mental Health Center have been translated into Spanish.

Special summer programs in remediation were operated during the summer of 1970, staffed by Center workers and volunteer tutor

therapists; they offered tutorial aid in the neighborhoods to raise the reading skill levels of school children.

Special summer tutorial and educational therapy involving 150 children with severe learning disabilities operates regularly each summer in the Center for Title I students. The children receive intensive tutoring two or three times weekly for a period of 8 weeks, while the parents receive counseling.

Mini Clinics. On an experimental and demonstration basis, a collaboration was worked out with the Board of Education Bureau of Child Guidance in the Title I schools to establish mini clinics, as they are called, on the premises of each school. A clinical team jointly staffed by the Mental Health Center and the Bureau of Child Guidance provides individual and family clinical services to the children in the school, to their parents, and to any other neighborhood resident who may wish to use the services of the mini clinic. Some school principals were initially fearful of establishing such services because "strangers" whom they could not control would be coming into the school building. The principals who have participated in the demonstration are most pleased with the service. Preliminary findings indicate that these mini clinics achieve the following:

- Provide quick crisis service to school personnel and children within the school.
- Provide quick referrals by breaking through the various mental health bureaucracies.
- Enhance the image of the school in the local community as an institution that is responsive to the needs of children and families in the neighborhood.

The mini clinics will continue to be evaluated on the basis of continuing experience.

Parent Involvement. A key to the success of all the collaborative programs is the involvement and participation of parents both in providing services and in policy and administrative decisionmaking about the services. Such parent involvement, and involvement of children and teenagers, in the planning of the programs have made it possible to reach the heretofore "unreachable" children, provide roots for the program in the communities and in the schools, and develop a substantive content and profound knowledge of needs. No educational or mental health professional can obtain this knowledge without actually living in and being part of the neighborhoods and the subcultures. Another consequence of this participation has been a much greater interest and involvement of parents and other neighborhood residents in school activities, in parent associations, and in community activities aimed at improving the schools.

UNSOLVED PROBLEMS

Several years of collaborative program development between Title I schools and the Community Mental Health Center have left certain problems still unsolved. Some of these problems are consequences of the internal dysfunctional structures built into the systems of education and health services in this country. Other problems observed might be summarized as follows:

Problems centered in the schools:

1. fragmentation of services and shortage of funds within the school
2. rivalry of special bureau and departments in the school system
3. inability of faculty to utilize all available resources around the needs of a given child
4. preoccupation of administrators and faculty with the mechanics of teaching and the maintenance of "tight ships" and "peaceful" organizations without regard to the mental health needs and problems of the pupils.
5. bureaucratic rigidities
6. the lack of mental health training and insights of educators
7. suspicion and hostility between parents and teachers, children and teachers

Problems centered in the Community Mental Health Center:

1. traditional, limited horizons of professional mental health workers who define service only in terms of psychopathology
2. lacks of funds for staff and programs
3. mental health funding sources placing emphasis on traditional clinical services
4. mental health personnel inexperienced with the nature and substance of school life and school problems
5. competition between school and mental health personnel working in community facilities

6. confusion concerning the definition and methods of primary, secondary and tertiary preventive programs
7. the general historic neglect of children's needs in the fields of psychiatry and mental health

Many of these problems are being defined, and solutions are being sought, in active and planned collaboration programs. Some never will be solved until fundamental changes are made in the structures of the systems.

CONCLUSION

Despite the various problems, experience in the Maimonides Community Mental Health Center-Title I Schools collaboration and in other similar programs throughout the country indicates a large measure of effectiveness and success in achieving the objectives of the programs.

Experience proves not only the value but the *absolute necessity* of such collaborations, if our children who need help are to receive it, and if preventive mental health is to diminish their numbers in the future.

Essential to the success of collaboration are:

- Mental Health Center initiative and out-reach to schools
- the *a priori* premise that both fields really want to help more effectively if the means can be found
- planned strategy, organizational techniques, and sophisticated human relations
- a demonstrated honest humility in mental health personnel regarding their inexperience with school life and their readiness to learn from school faculty, children, parents.

Collaborative programs demonstrate a principle and a fact of life. Whatever the limitations may be in a given situation, community, school or facility, dedicated, committed, compassionate, skillful educators and mental health workers can create the conditions for change and help greater numbers of children more effectively toward optimal emotional growth.

PRIMARY MENTAL HEALTH PROJECT

Rochester, N.Y., Emory Cohen, Ph.D.

SETTING

The Primary Mental Health Project (PMHP) has its headquarters at the Center for Community Study, an arm of the Psychology Department of the University of Rochester. The Center, located in a two-story converted dwelling about a mile and a half from the University campus, serves as the administrative, training, and research base for the project. Service operations center in the participating schools.

Rochester, a city of some 300,000, has experienced significant population shifts during the past two decades. While the city's population has declined during this period, surrounding areas of Monroe County have grown, swelling the county population to nearly three quarters of a million. These shifts primarily reflect a white exodus to the suburbs and an influx of minority groups to inner-city ghettos.

The Rochester City School District (RCSD) is responsible for educating approximately 45,000 children in the city. Surrounding county towns have their own educational programs. PMHP currently serves about 6,750 children located in 11 primary schools, six in RCSD and five in surrounding county districts. Five schools are K-3 and six are K-6; they range in size from 150 to 1,050, and in location from inner-city ghetto, with 97 percent nonwhite enrollment, to relatively affluent suburbs.

RATIONALE

The aims of PMHP are to maximize the educational and personal development of all children. The project operates in the large, amorphous, gray area between education and mental health. Its key methods are early detection and prevention of ineffective function—largely a before-the-fact-approach—in contrast to past emphasis on repairing gross maladaptation.

PMHP's origins, more than a decade ago, can be traced to two recurrent observations in schools. The first, a comment often made by teachers, was that in many classes more than 50 percent of the teacher's time was pre-empted by the maladaptation of two, three, or four children in a group of 25 or 30. This was upsetting to the teacher and detrimental to other children in the class as well as to the few presenting chronic management problems.

The second observation was of an upsurge in mental health referrals, many involving serious adaptive problems, during the transition period from elementary to high school. Examination of the child's prior cumulative record often indicated that the difficulties, in one or another form, had antecedents dating back to first or second grade. Either helping resources had been unavailable or people believed that if they closed their eyes long enough the difficulties would vanish. Far from vanishing, the problems often became more complex, firmly rooted, and disturbing as time passed. Children with early detected dysfunction were clearly candidates for later, more severe educational and mental health problems.

Thus, PMHP began in search of cures for these specific ills. At that time we had only hazily formulated the view that what we *really* wanted to do was to: cut down the flow of ineffective function; avoid the negative secondary complications of chronic educational failure; and bring about constructive change in individuals when they were young and pliable rather than when their problems had become more deeply entrenched. A decision was made to concentrate preventive services in the primary grades with full awareness that this would restrict services in the upper grades. Our long-term hope was to reduce the frequency of

chronic dysfunction and the need for later, more extensive helping services. We recognized that portions of traditional school mental health services would be lost because of this decision. However, in a world of scarce resources such as that of the mental health fields today, the choice that was made—from among those with many good objectives—was the one we viewed the *most* promising. Clearly, the value we expressed by our decision was that before-the-fact prevention is preferable to after-the-fact repair.

The school, as an institution that touches upon all members of society during their formative years, is an ideal setting for building potentiating environments and for early identification and curtailment of dysfunction. Other than the family, it is the most important child-shaping influence and, necessarily, a force that will either further or hinder development. Our decision to work in schools was determined by these considerations. Practically speaking, schools are an ideal target for those seeking to optimize human development and thus, to build a more effective society.

PLANNING

Initially, PMHP was a pilot demonstration project, autonomously funded, and limited to a single school. As the viability of the model was established, the potential value of its expansion became clearer. This brought into relief concrete questions of how its utilization base could be broadened and its system-wide impact increased. To achieve such ends requires that community planning and policy groups be aware of and support the project in question. In this community, the appropriate mental health planning body was the Rochester Mental Health Council. The Council had appointed a subcommittee to study existing school mental health programs and to make future recommendations for this area. PMHP staff worked closely with this committee during its survey of facilities, resources, and programs in Rochester and elsewhere. In its final report, the committee strongly endorsed PMHP as a basic model for school mental health services in this geographic locale. The committee's initial recommendation and subsequent powerful support in public relations and fundraising activities have been vital factors in expanding PMHP's base and in assuring its continuity.

Following committee endorsement of PMHP, project staff worked closely with the RCSD representatives and committee members to develop specific program plans. During this period meetings were also held with a number of surrounding County School Districts to acquaint them further with PMHP and to explore their interest in participating. The initial response to these meetings was encouraging in that a number of districts expressed strong interest in incorporating PMHP. Our aim was less to saturate a district with PMHP schools and more to have a broad base of participation from as many districts as possible. In that way, if PMHP rooted successfully even in one or two schools within a given district, there would be a firm basis for its proliferation.

The joint planning meetings led to the formulation of an operating framework for expanding PMHP which was agreeable to all parties. The project was to be located in a group of city and county schools representing varied circumstances. The basic model called for using portions of the time of a psychologist and social worker, plus 10 half-time child aides for each pair of schools. Costs for this expansion were calculated and categorized, roughly, as falling into three areas: program development and training; service; and research and evaluation. The decision was made to seek outside support for training and research, and for participating school districts to bear primary service costs. While these goals were eventually achieved, cutbacks in educational funding at the State level made it necessary to find local voluntary dollars to supplement limited school district monies available for the service portions of the program. This was done by the citizens' committee.

In parallel with the later phases of community planning there were many meetings between project staff and school district representatives (ranging from school board members to superintendents, pupil personnel directors, principals, and mental health clinical service personnel) to provide information about project background and workings, and administrative and fiscal matters.

During the summer of 1969, the project staff held a comprehensive series of planning conferences. We sought, without fully succeeding, to anticipate all problems that might be encountered in launching and conducting the program in diverse settings. These problems included preparing schools for the program, training professionals, recruiting and training nonprofessionals, and research evaluation.

Prior experience had indicated that it was not ideal simply to move into a school and start the project from Day One. There is need to orient personnel to project workings and for project-associated personnel to become known and accepted in the school. Accordingly, a plan was established to spend the first half of the initial year in "greasing the skids" in schools, training professionals, and then recruiting and training nonprofessionals as child aides.

When the school year started, the project staff met with the 11 school principals and district pupil-personnel service coordinators to discuss in detail how the project actually worked and to answer specific questions. Packets of informational material and reprints were provided. The project staff prepared a brief summary of its aims and methods and distributed multiple copies of this document to mental health professionals to use as a project primer for teachers and other school personnel.

School mental health professionals, though their styles differed, participated actively in preparing host schools for the project's imminent arrival. This included meeting with teachers to explain the project, similar meetings with PTA and parent groups, clarifying the range of problems falling within project purview, arranging schedules and space, and developing a specific referral system. Project staff, whenever appropriate, lent support to these activities as consultants or resource personnel. A second meeting for principals and pupil personnel directors was held at mid-year when professional and nonprofessional training was nearing completion and the project was about to get started in the schools.

TRAINING PROFESSIONALS

The six project psychologists and six social workers were seasoned and experienced persons, averaging 13 years of total professional experience and 7 years in their present functions. Their prior experience, however, was largely in the traditional mold of delivery of school mental health services. The objectives of the training sequence were less to imbue already skilled professionals with basic mental health principles and more to develop an alternate way of conceptualizing school mental health services (i.e., emphasizing early detection and prevention) and to talk about the "nuts and bolts" of implementing such programs. Specifically, activities such as consultation with school personnel, selection and training of nonprofessionals, and supervision of nonprofessionals were heavily emphasized.

A formal training curriculum for professionals was set up and weekly training meetings were held, starting at the beginning of the school year and continuing for 5 months. Further training meetings were held after completion of the formal curriculum; these were concrete, practical, and program-related and were less frequent.

An outline of the formal curriculum, together with suggested (voluntary) readings, was given to the professionals. This outline was periodically reviewed and modified as new needs and problems were identified.

In brief, the following topics were covered:

1. Overview, aims, and objectives of PMHP and its place in mental health programing.
2. Current problems in mental health: Demand-supply imbalances; effectiveness of existing methods; inequities in delivery of service.
3. Conceptual models in mental health: Medical model; preventive model.
4. Alternative utilizations of professional time; Social system analysis and modification; crisis intervention; mental health consultation; early detection of dysfunction; early secondary prevention.
5. Schools: Curriculum and development; the learning process and development.
6. Nonprofessionals: Rationale for use; brief history of this movement; consideration of specific programs; roles and functions; selection; training; supervision; special assets; limitations and potential problems. (Aides with several years of project experience participated in this phase of training.)
7. PMHP in detail: History; present plan; roles and activities; preparation of schools; record-keeping; supervision; research aspects; relations to nonprofessionals.

8. New roles for school mental health professionals: Prevention and system engineering; consultation in the schools; innovation; research.
9. Research aspects of PMHP: Review of past research orientation findings; significance of, and need for, research; scope of projected PMHP research; experimental orientation.

Later, as professionals became familiar with the schools and the needs and the problems of children, the need for additional training became apparent. Accordingly, five extra formal sessions were added to deal with topics such as behavior modification approaches and diagnosis and remediation of perceptual and learning disabilities.

Several other less formal training components proceeded in parallel with the large-group curriculum. Illustratively, the chief project psychologist met regularly with the six psychologists to talk in greater detail about specific project uses of assessment and screening devices, including administration, scoring, interpretation, and reporting. In like manner, the chief social worker met with the social workers to share information about methods of contacting and interviewing parents, recordkeeping, and reporting that had proven effective in the earlier history of the project. Finally, during the training period, the project staff made frequent school visits to get to know principals, teachers, other school personnel, and to help disseminate information about project objectives and methods.

Training meetings continued after the formal curriculum ended, averaging two or three per month. These later meetings corresponded in time with the start of the actual school programs. They were geared to practical day-to-day problems encountered by professionals in running the program and included what should be kept in records, working out patterns of supervisory responsibilities, fending off pressures in the schools for continuing a variety of traditional services, feedback mechanisms for school personnel, and coordination of efforts of team members.

TRAINING NONPROFESSIONALS

One of the earliest project findings was that there are many children who neither adapt effectively to school nor profit from the school experience. A historical limitation of early detection programs, however, is that resources needed for effective followthrough and correction have been lacking. Given the extent of school maladaptation problems and the dearth of professional resources to cope with them, there was need for rethinking existing patterns of manpower utilization. The compelling conclusion reached was that human qualities such as commitment, devotion, interest, and enthusiasm were attributes as important in helping young children in distress as the traditionally revered attributes of education, IQ, and formal degrees.

Although women have been used in many volunteer activities in schools in the past, the overwhelming tendency has been for them to be assigned menial functions. Our assumption is that carefully selected women have much, potentially, to offer in human service with maladapting school children. We considered carefully the characteristics that might be most useful in such work and decided that personal warmth, adeptness in interpersonal relations, interest in children, evidence of having been effective mothers, and possession of specific skills adaptable for work with children were primary. Accordingly, we formulated a brief description of the ideal aide and circulated it to a few colleagues and acquaintances who were asked to identify women they knew who fit the description. This approach had several advantages. First, it carried built-in prescreening calculated to minimize rejection rates. Second, we were not in a position to handle a wholesale flood of applicants that could have resulted from public announcements via the mass media. Actually as a result of some local newspaper and TV publicity we received a fair number of spontaneous inquiries from would-be child aides.

By late November 1969, we were ready to begin screening aide applicants. Professional teams were informed about selection criteria and characteristics that had been helpful in this process in the past. Interview rating scales reflecting a number of these attributes were provided. Each team, however, was given final say in its own selection process, since the professionals were the ones who would have to work on a daily basis with the child aides. During

this period direct contacts were initiated with inner-city agencies and organizations to encourage aide applicants since there had been no spontaneous applications from inner-city residents. This procedure developed a fair number of appropriate applicants.

All women who had expressed interest in the project were contacted, given the roster of project schools, and asked to rank their preferences for working in these schools. Inner-city schools were heavily favored by the applicant group as a whole. When these rankings were completed, the applicant pool was divided so that equal numbers were available to each pair of schools. School professionals arranged individual interviews with each person on their applicant sub-roster and selected from among these the ones they wished to appoint. Teams varied in the stringency of their screening criteria, but no team interviewed more than 25 candidates to find 10 seemingly good appointees. In all, 53 child aides were appointed in this manner and four senior aides acted as consultants.

At the end of the initial program period, we look back on this selection process with some satisfaction. The feeling of the school mental health professionals and other school personnel is that the aides, as a group, are first-rate. Only a very few have subsequently been dropped from the program because of unsatisfactory performance. Several others have been lost because of changing life circumstances (e.g., husbands assigned to a new job in another city, need for full-time work, etc.), but on the whole, the careful investment in selection has been repaid. Selected child aides were judged significantly higher on 18 interview characteristics (e.g., warmth, adjustment, flexibility, interest in children, adaptability, psychological-mindedness) than the group that was turned down.

Interviewing and recruiting prospective aides took place in November and December 1969, and their training, in parallel with the later stages of professional training, took place in January and February 1970. Most of the nonprofessional training was conducted by the school mental health professionals. This seemed desirable for several reasons: each group knew best what it wanted to emphasize and where its strengths lay; it was possible to manage group size (N=10 aides); and because the training situation offered the potential for welding a group esprit de corps. Project staff offered support and resources to facilitate the training of nonprofessionals. For example, the staff put together a detailed training manual (75 pages of outlined text and 25 pages of clinical case materials), developed strictly as a training resource for professionals, *not* as mandatory curriculum. Professionals were free to use it as they wished, to underplay certain areas, to introduce new ones, or to revise the sequence. The manual has proved to be a useful training aid which introduced homogeneity into a complex process occurring simultaneously in six different subgroups.

The aims of nonprofessional training were less to impart knowledge about the cumulated "wisdom" of the helping professions and more to provide a mental health orientation and to reduce the anxiety felt by most aides about the prospect of entering a heretofore sacrosanct arena of professional endeavor. The training program included three broad aspects: discussion-oriented meetings to consider substantive areas such as behavior-problems in children, normal child development, parent-child relations, school adaptation, the role of one child aide, and orientation to school and neighborhood; clinical exposure in terms of case history materials, films, and direct observation in the classroom, followed in each case by discussion of the primary data observed; and an introduction to pedagogic methods and teaching techniques with young children. Sessions were held twice weekly over a seven-week period.

All child aides had this bloc of formal training before starting to work with children. In addition, there has been continuous on-the-job training in the form of individual and group supervision, case conferences, and evaluation meetings about children with teachers and professionals, under the aegis of school mental health professionals and project consultants.

Although the nonprofessional training format was generally well received, most project participants, both professional and nonprofesional, believe that it would have been better had the aides actually started working with one or two children earlier in the training sequence. Instead of the "in-series" format of first learn-

ing abstractly and then doing, they would have preferred for these strands to develop "in-parallel."

THE PROJECT IN ACTION

While it would be convenient to think of PMHP as a homogeneous entity, it is far more accurate to describe it as a federation of subprograms, different in scope, specifics, and details, but sharing common philosophical objectives, long-term goals, and personnel utilizations. To provide a unified project description, a maximally saturated case is presented here, although such a program does not exist in toto in all schools.

EARLY DETECTION

The school mental health professionals have prime responsibility for judging a child's early school adaptation. To do so they use four classes of information:

1. The psychologist does gross intellectual and personality screening with all first grade children in small groups, using the California Test of Mental Maturity and Human Figure Drawings as prime evaluative tools.
2. Mental health professionals do direct classroom observation of children.
3. Teachers submit behavioral rating scale data for each first grade child including items measuring hyperactivity and aggressiveness, shyness, withdrawal, moodiness, and learning disabilities.
4. The social worker conducts individual interviews with mothers of first grade children to learn developmental history and family circumstances.

By pooling information and impressions gathered from these four sources, first grade youngsters were divided into two groups. The first, the so-called "Red Tag" group, included children who were already manifestly ineffective in behavior, educational progress, or both, or in whom such difficulties seemed imminent. All other youngsters were designated "Non-Red Tag," to indicate that they were functioning reasonably effectively. This classification was a confidential research judgment which was neither made part of the child's school record nor communicated *per se* to teachers or other school personnel. Overt labels that might have contributed to self-fulfilling prophecies, directly or indirectly, were avoided. Understandably, there was considerable overlap (as high as 85 to 90 percent) between youngsters identified as problem children by teachers and those classified as "Red Tag."

PMHP recasts the roles of school psychologists and social workers from one in which they are called on to step into the breach to handle acute crises—often culminating a lengthy, unhappy failure process in the child—to one in which, functioning as a team, they strive actively to identify problems early and to institute appropriate correctives. Activities such as individual testing and evaluation, crisis-oriented social work contacts, and therapy are replaced by educational, consultative, and resource functions with teachers, principals, and other school personnel as well as with nonprofessional program personnel, i.e., child aides. This shift in orientation is designed both to get at children's problems earlier, when there is greater hope of being helpful, and to expand, geometrically, the reach of helping services to the many school children who desperately need assistance but who do not otherwise receive it.

The professional is a consultant, particularly to teachers, in helping them to better understand relationships between psychological factors and educational progress, to evaluate the behavioral or educational problems posed by specific youngsters, and to plan special interventions for children who require extra help. It is not assumed that the professional automatically possesses refined, high-level, consultative skills. These skills are best acquired by living the new role and gaining concrete experience in it.

Experience has taught us that there is much to be gained from the active participation of teachers in consultative meetings to discuss and plan for specific children. While some of this can be achieved in occasional lunch hour or after-school meetings, to make it available systematically we provide substitute teachers 12 times per year per school. The substitute teacher spends a full day in 45 to 60 minute blocs, relieving classroom teachers to confer with professionals and child aides. This has been a constructive program element in that it provides an ongoing mechanism for teachers

to upgrade their knowledge of mental health principles and practices. The teacher, in confronting the thorny problems of individual children, acquires over time a practicum exposure which helps her to serve other children better and to handle classroom problems more directly and effectively.

POLICY AND SPACE

Each of the participating school districts determined its own policies with respect to pay levels for aides, merit ladders, and work hours. With the exception of inner-city aides who worked full time, all child aides were employed on a half-time basis. Space for project work, a perennial problem, varied in the different schools. Several had adequate office space for aides; most did not, and had to use the space of other part-time personnel such as nurses and reading teachers, flimsily screened-off conference rooms, and basement storage areas.

When actual contact work with children began in March 1970, the schools were familiar with the program in the abstract and keenly anticipated its action. Within 2 weeks after the program started, 250 youngsters were being seen regularly by aides.

The process of starting a child in the aide program is direct. Teachers bring to the mental health professional's attention children who display behavioral or educational problems. The teacher, aide, and mental health professional meet to pool available information and observations. Preliminary goals are established and educated guesses made about approaches and content emphases that the aide might use.

The aide begins to see the child regularly. Most often, the child is seen individually twice weekly for 30 to 40 minutes, although circumstances and specific needs or problems dictate flexibility. The aide has regular supervisory hours and often meets with teacher and professional as changes occur in the child, for better or for worse.

A special advantage of this format is that it brings teachers, aides, and professionals together around the shared objective of maximizing, through joint effort, the child's school development. Another advantage is that it establishes multiple observational perspectives and allows each group member to understand better the role-demands and pressures facing the others. When discrepant data arise (e.g., the child who "cuts-up" in class and is a "saint" with the aide) important clues are gained about his motivation and leads are provided for new strategems. Finally, the group discussion mechanism is a valuable learning device for teachers and aides. Its concrete, practical, child-serving focus is both palatable and ego-involving for them. At the same time, by considering general principles of behavior around the individual child, learning takes place that is transported back to the classroom. Several principals report that this growth in teacher learning, which increases front-line classroom management skills, is the prime PMHP value.

It is difficult to characterize the nature of aide-child interaction. Aides vary considerablly in interests, personalities, and styles. The range of activities that they engage in with children is very broad. The most significant common denominator cutting through all aide-child interactions is the attempt to establish a committed human relationship. More specifically however, the aide engages in direct educational activities in concert with the teacher, e.g., working with the child experiencing reading or number-concept deficiencies. Sometimes the aide may spend eight to ten sessions establishing a meaningful relationship with a child before undertaking educational activities. We have found such preparation to be useful with youngsters who have emotional blocks or mistrust adults associated with the educational enterprise. Often the form of educational instruction is unorthodox. It provides food for thought when a child who must struggle in class to add 2 + 2 and come up with an answer of 4 can add $200 to $200 when he passes "Go" in Monopoly and come up with the sum of $400!

Other activities that occur with some frequency in aide-child interactions include: *direct conversation,* both of a social and problem-centered nature; *participatory activities* including competitive games such as Monopoly or checkers and cooperative functions such as building things, working with expressive media together, or reading a story; *solitary activities* such as painting alone, or working with clay; and *recreational activities* in the form of organized games or play within the meeting room, in the

gymnasium, or on the school playground. It is an exception when aide and child spend a full 40-minute session on one activity. Usually, several different activities occur in units of 10, 15, or 20 minutes each.

Individualized patterns of aide supervision have been worked out by the teams. At one extreme, a team provides an hour a week of individual supervision per aide in addition to two weekly group supervisory conferences. Another pattern is to provide only brief individual supervisory contacts to aides (20 to 30 minutes per week). The staff has encouraged diversity in exploring supervisory patterns.

OFFSHOOT PROGRAMS

The child aide program has been a springboard for developing several other human service interventions in schools. We have used college students, retired people, indigenous inner-city mothers, and fourth graders as helpers for children requiring special assistance. "Trainees" simultaneously working in the program have ranged from 9-year-old schoolboys to 82-year-old grandmothers. These trainees have been characterized by their strong interest in children, their high degree of motivation, their energy, dedication, and enthusiasm. Whereas programs using nonprofessionals might initially have been justified on the basis of dire professional manpower shortages and fiscal austerity, our growing impression is that many such workers, by virtue of their natural adaptation to the setting, their freedom from jargon, and their flexibility, offer as much as professionals in helping maladapting school children.

Two specific observations can be made about these offshoot programs. Several, particularly those using retired people and inner-city workers, well reflect the potential of the "helper therapy" principle—i.e., the prospective value accruing to certain groups in society (e.g., the aged, the poor) from participating in a process that is genuinely helpful to another human being. A second observation pertains specifically to the retired aide program. It has potential for introducing adult male figures into the otherwise predominantly female world of the primary grades. Since virtually all problem-incidence and referral data for young children reflects disproportionally more boys and since many such instances are ones in which a male identification model is lacking for the male child, retired males have much to offer in ways that are also rewarding personally to them as aides for young school children. A point that should be emphasized, however, is that the call for nonprofessionals does not imply obsolescence for the professional; rather it points to the need for developing new, emergent, more socially utilitarian roles for him.

THE INNER-CITY

In the current PMHP expansion there are several schools with appreciable percentages of inner-city enrollees and one with 97 percent minority-group enrollment. This latter, a K-6 school, has a 75 percent white faculty, and its minority-group students are 74 percent black and 23 percent Spanish speaking.

When the professional mental health school workers reported in September, they found a backlog of more than 90 referrals waiting (the student population is 736). The referrals represented problems of sheer educational failure, lack of interest and motivation, and behavioral maladaptation.

The program was modified considerably in this school. Aides were hired from the immediate vicinity, including one who spoke Spanish. Their life-style and intimate knowledge of local conditions and problems equipped them for effective service in this setting. Since half-time positions were not feasible for most candidates, these inner-city aides were hired on a full-time basis. Within a short time aides were seeing 58 children in a single school. The training of inner-city aides was more action-oriented than concept-oriented, responding to the reality that educational failure is often a totally compelling fact of life for the inner-city school child.

To demonstrate how interaction patterns differed in inner-city settings, a preliminary data analysis system was designed. After each session with a child, the aides filled out process forms indicating time spent on various activities. The reports of five inner-city aides were compared with those of five non-inner-city aides. Both schools were staffed by the same psychologist and social worker, hence aide training, orientation to program, and guiding policy were

assumed to be similar in the two settings. The most striking difference between the two groups was that inner-city aides, responding to concrete educational deficiencies, spent 45 percent of their time in direct educational intervention as compared to 25 percent in the second school. Conversely, inner-city aides spent 12 percent of their time in cooperative activities in contrast to 27 percent in the comparison school, and 6 percent in aide- or child-dominated activities in contrast to 20 percent in the comparison school. These profile differences, in all likelihood, reflect two variables: the difference in problems manifested by children in the two settings, and different styles of the two aide groups.

Inner-city aides have tended to function in less schedule-bound ways than those in other settings, serving more often in a crisis capacity and seeing more children because of their full-time presence in the schools. Inner-city aides have also proved valuable in home visits by establishing communication with heretofore unapproachable parents. Because of style, greater similarity of background and speech, and familiarity with the neighborhood, they gain entrance to homes which would be closed to school personnel identified with an alien culture.

SPECIAL PROBLEMS

The PMHP network embraces six project staff members, 12 school mental health professionals, more than 100 teachers, scores of other school personnel, nearly 60 aides, varying numbers of help-agents, and many thousands of children and parents.

Such a complex net inevitably generates communication problems and breakdowns. Professional time is scarce and full briefing of involved persons is not always possible. Thus, teachers and administrators have sometimes been confused about project aims and methods and the types of children's problems with which it is concerned. In some settings there has been insufficient opportunity for communication between teachers and aides. The problems of communication gaps must be dealt with continually.

RESEARCH PROBLEMS

The basic research-embeddedness of the project requires careful study of all of its multiple facets—program effectiveness, aide characteristics, and process aspects. To do so requires methodological and substantive investigations that necessarily call for the time and effort of many people. The days of school personnel are typically full and often harried. Research pressures are viewed as "extra" demands, and research is seen as abstract and nonpractical. The respondent cannot readily see how his checkmarks on a piece of paper today will affect practice or service tomorrow. These factors realistically make data collection difficult, if not hazardous.

RAPPORT PROBLEMS

Project format requires that the psychologist and social worker function closely as a team in all settings, yet their pairings are essentially random. Team members, all seasoned, competent people, have different professional backgrounds, histories, orientations, attitudes, lifestyles, and personalities. In some instances, time and getting to know each other have permitted the necessary accommodation to take place; in others, such accommodations are still to be worked out.

ADAPTATION PROBLEMS

Professionals varied in their degree of comfort with the project format and methods. For most, the project meant a substantial change from long-established, secure ways of operating. This caused discomfort for some, perhaps complicated by the lack of full clarity in role-communication by project staff. Several professionals, for example, found one central project function, i.e., the supervision of aides, to be an uncomfortable chore. In these cases a greater burden was thrown on the partner and resentment was sometimes generated, forcing the project staff into the uneasy role of arbiter.

Key school personnel, including teachers and principals, often hold strong viewpoints and convictions and may see in PMHP, or similar programs, threats against tradition. The resultant problems may be resolved in most cases by time, dialogue, and consultative inter-

vention. When they exist, however, they are capable of reaching frustrating proportions and preempting scarce staff time.

TIME PROBLEMS

A psychologist or social worker assigned to a project school for only a half day or one day a week may be caught between two masters. The demands of teacher meetings, parent interviews, and aide supervision are pressing, and in an effort to meet them, assignments to other schools or to higher grade levels in the project school were sometimes deflected inadvertently. Negative reactions developed in nonproject personnel who saw the need for traditional services and found even fewer available than before. The harried professional often had no time to explain the project objectives to those not directly involved but was nevertheless affected by it.

This situation may be relieved by sharply restricting the scope of the project to a level realistically warranted by existing resources, and keeping administration informed as to project developments and progress so that, if possible, additional resources can be allocated to it in the future.

FUNDS

The fiscal solvency of PMHP, and many other projects in educational settings today, is at best tenuous. PMHP exists through a precarious combination of federal and voluntary funds, the latter available through a dedicated, supportive, and active citizens' committee. Inevitably these circumstances raise questions about the long-range potential of the project. The likelihood of continuity is increased, but not assured, by informed communication to the host systems, public relations activity, and strengthening of support bases with citizens, parents, teachers, and all those concerned with educational enterprise.

Initial teacher reactions were concerned with the program's limited scope and some mechanics of its function. Negative comments included "not enough aides," "program begun too late," and "more children need help." Others mentioned were "conflicts with prime class time," "insufficient contact between teacher and consultant," "scheduling problems for teachers," and "need for greater activity in crisis situations." Positive statements by teachers noted the value of the consultant's concerned interest, the new area of learning opened for teachers through participation in the consultation process, the value of the new perspective offered by the aides' observations, and the establishment of home contacts despite difficult circumstances. Teacher reactions, overall, favored the aims and philosophy of the program and its continuation.

PART B: CHAPTER TWO

RURAL SETTING

Range Mental Health Center, Virginia, Minnesota
Multi-County Mental Health Center, Tullahoma, Tennessee

THE RANGE MENTAL HEALTH-CENTER PROGRAM

Virginia, Minnesota, William Hunter, Ph.D.

SETTING

The Range Mental Health Center in Virginia, Minnesota, with a professional staff of seven, serves a population of 100,000 in the northern two-thirds of St. Louis County, adjacent to the Canadian border. The area covers a series of 14 mining towns situated along the Mesabi iron ore vein.

When the Center was established in 1962, these towns were significantly depressed economically because of the depletion of high grade iron ore reserves. At the present time, economic conditions are much improved as a result of conversion to the mining and processing of lower grade taconite ore.

There are approximately 20,000 school age children in the Center's catchment area. There are no psychiatric resources other than the Center. Two district offices of the County Department of Public Welfare provide family-oriented casework. The medical and legal professions, welfare and school personnel, police and clergy represent the traditional authorities who are consulted in time of crisis.

Some pockets of extreme poverty exist, such as the Nett Lake Indian Reservation and some small Finnish farming communities which have one or two room schools. About 75 percent of the Indian children drop out of school at the time of transfer from the Indian Reservation school to the junior high caucasian school. Many of those who do not drop out present severe educational problems. In other areas, there is a strong emphasis and support for education and over 90 percent of all high school graduates go on for advanced education.

The Range Mental Health Center staff provides consultation and educational services to 14 public school districts, 3 Catholic elementary schools, 3 junior colleges, 2 vocational schools, and several Head Start programs.

RATIONALE

In 1962 the beginning of a coordinated project between the Center and the schools sought to find solutions to two concrete problems:

1. How to provide maximally effective mental health services to an area of approximately 4,000 square miles.
2. How to distribute services equitably to all population centers within this area.

School administrators and teachers were expressing concern about the unmet needs of emotionally disturbed children. There was equal concern about the many children who were not diagnosed as emotionally ill, but who exhibited occasional disturbed behavior and were candidates for preventive intervention.

The Center's staff of seven could not possibly employ traditional therapies with the majority of these children. Even if an adequate staff had been available, experience had shown that many families were neither interested in nor receptive to involvement in therapeutic ventures with their children. Transportation was a large problem in an area almost entirely dependent on private cars, and many parents were unable to pay for child care at home while they attended Center therapy sessions.

A common problem presented by school personnel was the number of children with poor school adjustment and resultant poor performance. Many had a confused and devalued self-image, difficulty in relating to peers, conflicts with authority figures, inadequate opportunity for basic social experiences, and home situations which exacerbated these conditions.

Personally, my experience in a community mental health center had been intensely frustrating. The traditional medical model did not fit the majority of my clients. Traditional psychiatric treatment seemed of little value in working with large numbers of troubled children and adolescents. I decided, with trepidation, to venture into the schools as a mental health consultant to ascertain if I could offer more in this type of role.

Except for the family, teachers have the most sustained relationship with children over an extended period of time. It seemed a reasonable hypothesis to the Center staff that through mental health consultation, teachers could become more effective workers in the *prevention* of emotional disturbance in children, as well as more competent in classroom management of already evident disturbance. Through consultation with school personnel, the total impact of the Center's small staff could be tremendously expanded.

Accordingly, the project of partners in programming was begun.

PLANNING

At the outset certain priority decisions were made:

1. Children and adolescents were the first priority group.
2. A large portion of the available mental health manpower would be allocated to the schools.
3. The mental health program would concentrate on consultation to school personnel rather than on direct clinical services.

In the school setting, mental health consultation is focused on the child's difficulties in coping with the educational environment. The mental health consultant works with the teacher to assist him in more adequately managing the teacher-child relationship. This, in turn, should reduce or prevent interference with the child's learning behavior.

The basic aim of consultation is prevention rather than remediation. If children's problems or "crises" can be handled by school personnel in a competence building manner, both the teacher and child should come to feel more adequate since both are building a repertoire of positive types of behavior.

The goal of consultation in the schools is to enhance the awareness of teachers in observing and understanding the behavior of the children they have in their classrooms and to improve and expand their educational techniques. The goal is, in essence, an attempt to assist the schools in providing for the fullest development of their faculty and of their programs in meeting the needs of the individual student.

The difference between consultation as used at the Range Mental Health Center, and the common concept of consultation, lies in the fact that most consultants are called upon to give advice on one specific problem. Having done so, they depart to return upon request. However, our method involves being in the school regularly whether a specific consultation request is presented or not. In this way we can also assist school personnel to become aware of problems that in their earlier stages go unnoticed and later mushroom into marked management problems.

Also, in our consultation program we try not to simply "give advice" on problems presented to us; rather, we try to furnish means whereby the school person can develop his own way of dealing with the problem on a continued basis in accordance with his own needs and style.

An essential aspect of consultation, as defined here, is that the professional responsibility for the child remains with the school person. The consultant may offer helpful clarifications, diagnostic interpretations, or advice on management, but the teacher is free to accept or reject all or part of this help. Action for the benefit of the child which emerges from the consultation is the responsibility of the teacher.

The consultative method is specifically nonjudgmental and has no strings attached. It does not have any connection with a school's internal policies, employment, tenure, advancement, or increase in salary.

Consultation differs from supervision in that the supervisor has an administrative responsibility for outcome, must assure that the work is completed, evaluate it, and transmit organizational expectations. The consultant's responsibility is advisory.

The consultant trains through the examination of problems. He usually does not take formal responsibility for training, nor does he

utilize formal educational arrangements and methods. Such programs may be the outgrowth of consultation, and this does happen at the Range Mental Health Center. Training through consultation, because it arises out of what the teacher brings into the sessions, is opportunistic in nature. Inservice and professional training methods are more organized.

Consultation may resemble psychotherapy and casework very closely when the focus is on the feelings and relationships of the consultees. The aim of consultation is to assist the consultee to perform his job more efficiently and to help him solve his problems. Setting a clear focus and limit to the relationship differentiates the activity from psychotherapy.

The consultant, as an extension of his role as consultant or trainer, may choose to see a child directly for evaluation purposes, or may develop a demonstration of a particular method in which he includes his consultees as collaborators.

The mental health consultant working in the schools is *not* an educational supervisor. From our point of view we don't monitor the teacher to ascertain if she has a syllabus, uses a lesson plan, or has the approved text, so long as her efforts are successful in preventing emotional disturbance in children. That may be someone's concern; it is not ours.

We expect to hear of the teacher's deficiencies, anxieties, errors, but through an honest analysis of any or all of these human experiences will come greater professional competencies.

By removing all judging and rating aspects we find that the teacher becomes less defensive, and begins to utilize the consultation process to upgrade her help-giving skills. Thus, the consultant's essential function is not to do it, but to enable the teacher to do it, and the most brilliant ideas I have as a consultant are useless until the teacher reconceptualizes them into her own framework.

Taking into account the number and variety of disturbed children in the schools throughout the country and the amount of anxiety and frustration among teachers and principals who have to deal with these children, it is our opinion that the consultation method best assists those involved with the child to survive and grow, and at the same time help disturbed children to progress.

It is by no means an easy matter to learn how to make one's expertise fully serviceable through consultation. Perhaps one of the most difficult lessons for the mental health consultant to learn is that neither the teacher who is the consultee, nor the pupil who is the concern of the teacher, is to be regarded or treated as a patient, client, or counselee. This requires a reorientation of point of view and learning of a new method in helping people, especially for those who are trained to function primarily as psychotherapists.

A mental health consultant should not view it as his task to "revamp" the whole school system or to change the overall policies, equipment, or administrative organization unless he has been specifically employed to do so.

A mental health consultant owes it to the school personnel with whom he consults to respect their professional sphere and to make it his business to learn something about their way of working, their goals, and their philosophies. He must respect their language and be careful not to impose his own language on them.

The successful consultant learns to recognize and work with the integrative potential of his consultee. He must be able to assess, in the most distraught teacher or administrator's presentation of his work problems, what his strengths and assets are that can be used to reduce and eventually solve these problems. The specific aims of school consultation are:

1. To increase the psychological sophistication of school personnel and to enhance teachers' concepts of mental health in children.
2. To instill in school personnel a clear comprehension and stronger appreciation for preventive mental health practices with children.
3. To improve the abilities of school personnel to recognize and adequately interpret various behavior indicators of potential maladaptive functioning in children.

Both the mental health consultant and the school person must work in an atmosphere of trust in which real communication can occur. Initially because of differing backgrounds these two individuals may not use symbols and words in the same way. It will take some time to clarify language and points of view before meaningful communication takes place.

HOW WE WENT ABOUT SETTING UP OUR CONSULTATION PROGRAM

I would like to emphasize that if a mental health consultant program in a school is to be successful much planning needs to take place prior to its initiation. Our experience revealed a three-phase developmental process.

1. Sanctions phase
2. Beginning phase
3. Problems solving phase

These phases are not mutually exclusive. They do not evolve in exactly this neat or orderly fashion but rather overlap and frequently blend one into the other. For instance, the beginning phase may be completed in one session or may extend to a number of sessions. Problem solving may be a part of any one of the phases. The consultant may consciously attempt to include a problem solving experience for the prospective consultee in the sanctions phase, as a way of demonstrating the value of the mental health consultation process.

During the sanctions phase, we interpreted and offered consultative services. Since consultation services were new and unknown in this area, these services were introduced by a number of our staff visiting each school superintendent in the area and describing the goals of the program briefly and stating that consultation service was available.

Reactions of superintendents and principals were varied. One superintendent was obviously very threatened and declined our services. I learned later he thought we were in his office to psychoanalyze him. Many administrators immediately requested that our Center perform their psychological testing of the mentally retarded or attempted to use us as a "dumping ground" for anti-social and acting-out children. They expressed disappointment when we informed them that this was not our goal in offering consultation services to the schools.

A high school principal was emphatic in stating that we should stay in our office and treat the "sick parents and children" he wanted to refer to us. Some school personnel indicated there were no "problem children" in the district and they did not feel that our agency had anything to offer them.

However, after two months of negotiating we obtained entry sanctions from all the school districts in our area. In planning such a program, it would be wise to assume school personnel are going to be somewhat negative or indifferent at the outset. The degree of acceptance of mental health services will initially be highly contingent on school personnel's preconceived ideas.

At the time school started in September 1962, we met first with the principals in the district and then with the faculty. We gave each group a detailed orientation to our mental health services in general, and to the consultation services in particular. This should be done each year to reorient old teachers and reach the new ones as they enter the school district.

The beginning phase centers around the first consultation session and the development of a contract. The contract is simply an agreement to use consultative services. This may take place at the time of the sanctions phase or may occur around a crisis event, or may materialize some time after one or more consultation experiences. The contract is usually a verbal agreement in which the consultant and school personnel work out details such as who will participate and where and when consultation will take place.

The problem solving phase is the heart of the consultation process. Ideally, each time the consultant and the teacher meet, the teacher presents an interpersonal problem encountered in his work that interferes with his ability to effectively exercise his professional role. The length of time varies for the evolution of this process, and for the teacher to perceive that the consultation relationship is helpful. The consultant's acceptance of the teacher, his helping the teacher to focus on the central theme, and his dynamic understanding of behavior all play important parts in establishing the consultant's effectiveness.

In implementing the consultative role with schools in the Range area, a mental health consultant visits, on a regular basis, each school district to assist with problems that children are presenting to the teaching staff. We make an effort to familiarize ourselves with the prevailing philosophy of that particular school. In a less intensive fashion, we grow to know the

children and something of the classroom atmosphere.

We seek to help teachers and administrators by demonstrating ways in which they can observe, understand, and manage more successfully the problems that confront them. The consultative method differs from supervision, discipline, and use of school counselors or school psychologists in that members of the Center team rarely deal directly with the child in question, and never without parental consent.

Teachers often feel that unless the child is seen, nothing tangible can be accomplished. It is easy to understand this attitude, but it is important for the teacher to realize that the consultant's function is not to "cure" a child. Rather, it is to help the teacher determine how he can best aid the child in class.

While the consultation is primarily directed to assist the teacher, the principal also plays a crucial role. A school may have fine, sensitively attuned teachers, but if a principal resists or fears consultation of this kind, the teachers either will feel too threatened to request consultation or will not be able to put into practice the things they have learned.

One technique we found helpful in enhancing the consultation program was to request that each school district develop a mental health coordinating committee made up of key personnel within the school. All requests for consultation were directed to the chairman of this committee. It was the committee's responsibility to plan the activities of the Range Mental Health Center consultant while he was in that school.

This technique permitted each school district to apportion its available mental health manpower in whatever manner it felt would best utilize the consultation services to meet priority needs at a particular time.

In the past, mental health workers have all too frequently made school personnel feel inadequate in terms of their ability to deal with human problems. They have persuaded them that all psychiatric problems could be solved if there were only enough psychiatrists. This is diametrically opposed to the Range Mental Health Center's philosophy. The consultant's job, as we view it, is to stress the contribution the consultee makes as a member of the mental health team. Teachers have a tendency to underrate what they can accomplish through change in the classroom setting.

From our point of view, we found it essential that our psychiatrists and psychologists appreciate the realistic difficulties that school personnel encounter in trying to modify children's behavior. They must guard against having a "know-it-all" attitude. Mental health professionals need to be careful of reacting to either of the conceptions of the "Reformer" or the "Mr. Fixit." If staff members of a Center have had little or no previous experience in working with school personnel it is imperative that they receive inservice training which will assist them in understanding the internal operation and philosophy of schools.

Also, consultation sessions are seldom filled with dramatic wisdom. Most of the consultant's efforts involve support, encouragement, sharing of and sympathizing with difficult situations, identifying options, and inservice training.

The consultant is not there to say what is right or wrong, but to increase the number of possibilities the consultee will consider in any particular situation. The consultant hopes to widen the horizons of the person with whom he is working. He must always respect the need of this person to make decisions on his own at the moment when he or she is dealing with an individual child.

Unless the mental health consultant is explicit in defining his role, school personnel will be at a loss as to how to utilize him. Also, unless his role is clearly defined, expectations can, inadvertently, become unrealistic and inappropriate, e.g., rewrite an arithmetic curriculum, decide on educational policy for the entire school system, attend union hearings, and go on home visits. These are all valuable functions but not within the realm of the role of helping the teachers and administrative staff to solve their problems, especially in relation to the school's effect on children with problems.

Initially, the Range Mental Health Center staff, trying to emphasize prevention and early recognition of children's problems, presented a number of lectures in various elementary schools. These capsule seminars included topics of interest to teachers such as reading problems, underachievement, discipline, and basic aspects of mental health. Later such topics as

interviewing techniques, how to use a relationship, open and submerged hostility, and early recognition of danger signs in children were pursued.

The prime message that the Center staff wanted to communicate was not what to do *for* children in trouble but how to work *with* children in trouble. The seminars emphasized the point of view that children's confusion can be understood and helped, and that interest, warmth and concern are often more important in helping troubled people than special knowledge and training.

Questions raised and cases discussed in the seminars were of interest both because they indicated the kinds of problems teachers in the school face, and because they showed the effectiveness of the learning process. Teachers and guidance personnel became more comfortable about working with parents. There was less of "Where can I send this problem?" and more of "How can *I* help this child and family?"

SEQUENCE OF PROBLEMS PRESENTED

It has been interesting to note that as mental health consultants we see a certain sequence of problems presented to us upon initiating consultation in a school system.

1. "See the child who is disturbing my classroom!" Invariably the first thing Center staff members are asked is to give assistance on individual cases of children who are disturbing the class or the whole school. This is true, even though we have tried to make it clear that our ultimate goal was to help the staff. Following the rule that we take a school as we find it, we attempt to help in the individual cases presented to us. By doing so, we try to show our willingness to help.

We do not refuse a request to deal with emergency issues simply because we do not have the answers. Too often teachers get the feeling, and for good reasons, that consultants are unwilling to grapple with the dirty work when it arises.

2. The Bugaboo of Parents! The second issue in which our mental health consultants are asked to help is the parent-teacher relationship. Parents can be a frightened and frightening group of people. Where people are frightened of each other, they behave defensively and manage to avoid the kind of communication for which parent conferences are scheduled.

Parents sometimes look upon teachers as some patients look at psychiatrists: "Here all is revealed, and I am to be judged and found wanting." On the other-side, teachers are often uncomfortable in their role. They are, as a group, oversensitive to criticism and tend to feel that the parents will attack their methods, opinions and grading system.

When such fears prevail the idea on both sides is to get the whole thing over as fast and as painlessly as possible. If polite conversation and positive remarks prevail, how does one say what needs to be said about the child and how does one learn of the key issues, i.e., the mother's feelings, fears, aspirations and worries?

At times the Range Mental Health Center staff member is asked to participate in a parent-teacher conference. This is done when the teacher is particularly unsure or frightened of the parent, when the child presents very particular problems which need to be dealt with at home, or when the parent is too anxious or prejudiced by past conferences to listen to the teacher. A member of an outside agency provides a means for keeping the problem in focus and on an objective basis.

More often the consultant reviews the case, works with the teacher in getting a total picture, explores the teacher's feelings about the child, about that particular parent, and about parents in general. He may role-play with the teacher as to how the conference might be handled.

We have found the most effective guidelines we can give a teacher on parent conferences is to work more by setting an example than by giving advice. The way in which we handle our interviews with the teacher are, for good or bad, demonstrations in interviewing. Without having to say so, in time the teacher eliminates some of her judgmental approach to parents, tries to help the parents be at ease without evading the issues, and uses some of our methods to help clarify what is being said so that both parent and teacher can understand the purpose of the meeting.

3. Staff Problems. After a number of individual cases and parent conferences, the teachers

begin to know us well enough so that we are invited to approach their own problems. The principal, too, by then has talked over not just the cases of Billy or Susan, but has taken time with us to talk over his concern about the way Mrs. G or Mr. M is handling her or his class.

Finally, the principal may want to talk about himself, his problems and victories, how he deals with the children, parents and staff, and the impact of his administration on the total school program.

TEACHERS' EXPECTATION OF CONSULTATION

Our experience has shown that school personnel tend to expect too high a level of results from consultation. Sometimes attention should be directed to the fact that many problems of youngsters are of a long-standing nature. They are not easily modified and therefore, the teacher's expectations should not be unduly high.

Secondly, it is important that the teacher recognize that the learning process itself provides therapeutic experiences for the child. A teacher's patient guidance of the child so that he can take the next step in acquisition of skills and knowledge is vital to the child's feelings that someone cares and believes that he can be a more competent and successful human being.

Third, the teacher needs help in understanding how each child's already acquired methods of relating to adults in his environment can slowly be altered by new experiences through the teacher's interaction with the child.

For example, the emotionally disturbed child has often learned that his temper outbursts in the face of learning tasks usually result in the adult's withdrawal of the task and the introduction of punitive measures. Such a child desperately needs to experience an adult who can live through these temper outbursts with him and who can then firmly help him carry out the learning task. From such experiences the child begins to develop a different and positive image of himself, of the adults around him, and of his own capacities to learn.

A CASE EXAMPLE OF CONSULTATION

A kindergarten teacher in a small consolidated school in the Superior National Forest brought this case to my attention during one of my regular monthly visits to the school. Five year old Paul had been enrolled in kindergarten by his mother. The family lived in an isolated area with few neighbors. The boy's mother was a war bride and reported to the kindergarten teacher that she was very unhappy about living in the United States. Paul was hyperactive, had a short attention span, and had few social skills. After our discussion, it was obvious that there was much psychopathology in the family.

I wondered, at that time, if the kindergarten teacher would be able to control the child enough to keep him in school, but I made some suggestions as to how she might set limits and suggested that she begin to establish a therapeutic relationship with the boy. Each month when I returned I would hear of the many interactions that transpired, and of the successes and failures. At my suggestion, the kindergarten teacher began to call Paul's mother twice weekly to exchange information and verify impressions. The teacher's efforts to set limits began to work, and the child became less destructive and assaultive in the classroom setting.

By the end of the school year the kindergarten teacher had established a strong therapeutic relationship with Paul, had been able to guide his mother in setting some limits at home, and had helped her become less rejecting of the child. The boy was so disturbed that he had not been able to profit very much from his kindergarten experience, and I suggested that he repeat kindergarten.

In this particular school district, there was a policy that when a child repeated a grade he was transferred to a different teacher for the second year. I felt it would be unwise to transfer this child to another teacher and recommended that the superintendent make an exception to the established rule to permit the child to repeat the grade with the same teacher. My recommendation was followed.

At the beginning of the second year of kindergarten the teacher noted some regression, but she was soon able to recoup what had been lost during the summer vacation. Each month of the first semester of the second year I heard of less and less disturbed behavior by the boy. During the second semester, Paul was able to actively engage in the learning process in a

group setting and was able to assimilate pre-reading activities.

The kindergarten teacher continued her telephone contacts with the mother during the second year. She was able to arrange three face-to-face conferences with the parents to review Paul's progress and to enlist both parents in the therapeutic program.

The comments of the kindergarten teacher during the June consultation period of the second year were very enlightening. She informed me that she had been extremely angry with me when I had suggested that the boy repeat kindergarten and continue his placement with her. She stated, "I felt that I had done my duty and given my pound of flesh, and it should be someone else's turn! Now that I have had the boy a second year I understand exactly why you made that recommendation. It would have been a mistake to transfer the child to another teacher because he would probably have lost the good effects of my work with him."

It was very gratifying to me as a consultant to watch his teacher's increased awareness of this culturally deprived, isolated and rejected child's needs as she worked with him over a two-year period. As Paul has moved on through the grades he has not been one of the best students, but conversely he has not been the poorest either.

It is my feeling that this case illustrates the positive impact that a consultant can have if he is willing to expend the effort and time in working with teaching personnel. I feel quite strongly that it would have been impossible to get such positive results utilizing outpatient therapy. The boy's parents would have refused to come in, and the case would have been disposed of by saying simply that the parents were not motivated to obtain treatment.

SOME PERSONAL OBSERVATIONS WHILE WORKING AS A MENTAL HEALTH CONSULTANT IN SCHOOLS

The 15 school districts were divided among the staff members of the Mental Health Center. I assumed responsibility for two, which I will designate as School A and School B. My goals were lofty as I embarked on my consultation rounds. However, I soon found myself blocked whenever I made efforts to initiate interaction with teachers in these two school systems. There was resistance in the air and in each school the resistance was of a different order. In School A it was largely passive and tended to be acted out in such things as forgotten appointments, scrambled communications, and maintenance of personal distances. At School B, the staff seemed more open in their communications with me. They were for or against me in an all-or-nothing way that neither I nor they doubted their attitudes toward me. To be sure, there was resistance, but it was active and not passive.

Why such formidable resistance? I have some speculations which I can offer. Teachers are often under fire and since Sputnik, criticism has increased. They feared such criticism from me and certainly did not see me as someone who would help them. Many teachers have seen so-called consultants come and go, and they have rarely profited from these endeavors. Also, in their travels through academia, they have been exposed to psychiatric jargon, and they despair of ever understanding or being understood. I would like to describe some of my impressions of the 2 school districts.

School A is a large, impersonal machine which appears to be run by the book and by the clock. Administrators are rarely visible. Memoranda are preferred to face-to-face communications, and decisionmaking occurs at the bureaucratic center and diffuses outward on a line and staff model. Teachers tend to be curriculum dominated and view the understanding or counseling of students as a very secondary part of their role as teachers. Teachers with whom I met were guarded and prone to intellectualize. The majority of the students in the school are middle class and college bound. Deviant behavior tends to be defined as that which does not conform to middle class standards.

School B is a smaller school with a less rigid atmosphere. The principal is often seen consulting with teachers or students in an impromptu fashion. Staff members know one another and meet without formality. Communications are open and lateral, and teachers participate in decisionmaking and/or are encouraged to air their views. Many of School B's students are not college bound but will find

jobs in local mining operations or emigrate to the Minneapolis-St. Paul industrial area.

School B acknowledges many unsolved problems. It cannot yet meet the needs of such groups as gifted students for whom the pace is too slow; students with a negative attitude toward school; or students who require much remedial work in basic subjects such as English and mathematics.

I asked myself what these differences in the two schools do to the emotional development of the children who pass through the systems, and how I, as a consultant could have some positive impact in both systems. In the case of School A, the role of the mental health consultant became one of helping to improve a school environment that was not particularly conducive to healthy emotional development. In the case of School B, it was mainly one of helping with individual student problems and helping to facilitate student-teacher interaction.

I wish I could report that after several years of consultation a great many changes have taken place in School A, but unfortunately this is not so. Changes have been small, and School A still has far to go toward developing an atmosphere that is less mechanistic and authoritarian. On the other hand, my relationship with School B has matured to the point where my consultation is actively sought and I view many of the school administrators and teachers as close friends. Several innovative programs have evolved from long term consultation relationships with this school.

Experience suggests that unless a consultant can establish a basic trust relationship with school personnel in a district, a consultation program has little chance for effectiveness. This basic trust relationship cannot exist unless the consultant respects the school personnel. He must learn their goals and philosophies, their ways of working, and their language, as individuals and as components of a system.

The consultant's task is not to actively change a school system, its policies, equipment, or administrative organization, but to assist in a nonjudgmental way in the understanding of the behavior of children. Only then can the consultant help the teacher to develop his own way of managing the teacher-child relationship. The consultant's essential function is *not to do the job, but to enable the teacher to do it.*

PROGRAMS STEMMING FROM CONSULTATION SERVICES

Psychoeducational Consultation. Through the consultation program, the mental health staff became keenly aware of inadequacies of the Center to provide techniques for dealing with educational deficits. This led to the establishment of a totally new position in the Center—that of psychoeducational consultant. This consultant, a clinician with experience in teaching both normal and multiple-handicapped children, was recruited from a university where she taught graduate courses in special education.

The duties of the psychoeducational consultant include providing a high level of expertise to school personnel, kindergarten through twelfth grade, in specific techniques of dealing with special learning difficulties. This staff person develops and conducts inservice education programs for teachers and assists them in developing special learning disability materials to overcome educational deficits in their students. On request she does demonstration teaching and conducts joint interviews with teachers and parents.

Special Learning Disabilities Clinic. One school district, with encouragement from the Mental Health Center, has developed a special learning disabilities clinic within the school. A program evolved whereby children can receive services ranging from as little as 20 minutes per week of remedial tutoring up to and including a complete self-contained classroom for very disturbed children.

Based upon the success of this initial pilot project, and with the expert assistance of the psychoeducational consultant, seven other school districts in this area are now at various stages of developing special learning disabilities programs based upon their unique needs.

It is important to point out that many of these programs are utilizing a resource model employing local teachers who have been given training in SLD techniques by members of the Range Mental Health Center staff and academic personnel from the University of Minnesota. One group of SLD teachers participated in a tele-

lecture series emanating from the University of Minnesota as part of their training.

The resource model is one which uses the specialized services as ancillary and supportive to the teacher in the classroom. It is hoped that this model will prevent the special program from becoming an end in itself, but instead provide a means of helping the student meet success in the regular classroom.

Pre-adolescent Boys Program. Consultation in one school district led to the identification of approximately 15 emotionally disturbed, socially inept, pre-adolescent boys. They shared one major lack—a sustained relationship with an 'ego-ideal' figure. Center collaboration with the director of a school-based SLD clinic established an activity-oriented group program meeting in an elementary school for 2 hours weekly. After a year, male junior college students were recruited and trained to conduct this program with supervision of school personnel.

This program is based on several factors: (1) extension of the special skills of mental health professionals; (2) friendship as a reparative tool for handling feelings of self-effacement and as a countervailing force to peer group and community stigmatization; (3) the college student as a non-stigmatizing therapeutic agent; (4) opportunity for reaching children in therapeutically difficult life situations; and (5) provision of informal opportunities for social growth.

It has proven adaptable to both the emotional and learning needs of children whose functioning has been affected by the noxious influences of traumatizing factors and/or deprivations.

Cerebral Palsy Clinic. Local school personnel are part of the staff of a highly specialized Mental Health Center operated clinic to evaluate children diagnosed as having cerebral palsy. This is the only such clinic in northern Minnesota.

Parent Workshop. Local school districts and Center staff collaborate in conducting half-day workshops for parents of children about to enter kindergarten. Speakers highlight what will be expected of the child upon school admission, clarify what the parents can do to prepare the child, and thus attempt to reduce the trauma for the child.

Community Coordination. Through joint consultations with the Center staff, school personnel and other agencies or workers involved with a single family meet to exchange information and views and to develop comprehensive programs for multiproblem families. There have been several cases of effective service planning where previously chaos had existed due to breakdowns in communication among involved resources.

The Center has also been instrumental in getting local school districts to cooperate in developing school psychological services on an interdistrict basis.

Training. Exposure to mental health concepts is given at all levels of teacher training—undergraduate, graduate, and inservice training. The Center staff are faculty members of the University of Minnesota and state colleges, and they offer classes in child psychology and mental health concepts. Complete inservice training programs for schools are provided upon request. Video tapes for demonstration teaching are in the process of development.

CONCLUSION

If any impact is to be made on mental illness in the future, more emphasis must be placed on working with school age children. Mental Health Center staff members and school personnel have unique expertise that, when combined into a viable program, can have great effect on children who show signs of emotional disturbance.

The Range Mental Health Center has developed joint programs and services with all the school districts in its catchment area. These consultation and educational services are rendered at an economical cost both in terms of manpower and money. Service is provided to children and parents who have been ignored in traditional mental health programs—poverty, Indian and rural groups.

Before embarking on the type of program outlined in this article, both school and mental health personnel must be willing to make a substantial commitment to the program in time

and training activities. It is the type of program that produces long-term gains rather than flashy, immediate results.

After 8 years of consultation experience in schools, the staff of the Range Mental Health Center feels that a good consultant can effect change without benefit of executive authority. By sensitive listening and lucid speaking, by concerning himself with the understanding of the consultee's problems and his potentialities, by thinking with him, but from a different orientation and out of a different backlog of experience, he can move with his consultee from one new vantage point to another until the consultee begins to gain new perspective, conceive new ideas, and glimpse how they may be adapted to his need. Anxieties, faults, deficits, and self-doubts are the very things out of which professional and personal growth in the teacher may take place. These are the seeds from which new insights, awareness, interest, and richer performance grow.

The conclusion is that teachers need and want consultation from individuals whose experience with children and adults enables them to understand the causes underlying disruptive behavior.

Such consultation, when effective, can significantly assist teachers to help disturbed children become more effective human beings and help *all* children toward optimal social and emotional development.

MULTI-COUNTY MENTAL HEALTH CENTER SCHOOL CONSULTATION

Tullahoma, Tennessee, John Carver, Ph.D.

SETTING

The Multi-County Mental Health Center serves five rural, middle Tennessee counties. Eight public school systems serve the area's 27,150 school children, including approximately 7,100 children from poverty homes. Prior to the establishment of the mental health center, there were no mental health services *per se* either public or private in the five counties. Schools receive some psychological testing service from the State Department of Education, however. No school psychologists are employed by any system, although most secondary schools do have guidance counselors. In one system an elementary guidance teacher serves all the elementary schools. Most of the systems have special education for the retarded; none have special classes for the emotionally disturbed. With the Mental Health Center serving as catalyst, however, one system did set up a special school for teaching disabled children.

We were eager that the Mental Health Center develop plans to provide adequate services for a majority of children. The concern with numbers grew out of a painful awareness that traditional outpatient service reaches only a small percentage of disturbed children, leaves systems virtually unchanged, and does not even address itself to prevention. Schools offer the manpower and the model service delivery system which mental health so sorely lacks. They offer preventive potential as yet quite undeveloped.

School systems are in daily contact with many more problem children than are mental health centers. Of all the alcoholics, drug addicts, criminals, mentally disturbed, vocationally or maritally maladjusted people in our society, very few have not been under the influence of the educational system. The task for schools must be affective education as well as cognitive, for there is no other agency which can adequately serve this end. The popular system of separating out specific children for referral to other resources has been grossly overused. It has allowed both educators and mental health authorities to avoid seeing the school as the primary mental health agency in the community.

Our aim for children in designing the Multi-County Mental Health Center was to obligate our staff to help education answer its obligation to children, not to serve as a referral dumping ground or fix-it station to weed out children whose behavior had been categorized through some artificial pattern of labeling. Our precepts of operation included the following biases:

1. Mental health programming should be committed to *prevention* of emotional disorders by whatever means available.
2. Direct traditional patient services should, whenever possible, include a training element so that we impart our skills to others at every available opportunity. This means that volunteers, teachers, and others are included in sessions as trainees.
3. That clinical purity in the traditional sense is far less important to the general public good than overall program effectiveness in reducing the incidence of mental disorders and in promoting mental health in the community at large.
4. That the most effective approach is one of strengthening all possible elements which enhance growth rather than doing spot remediation of problem children.

5. That the primary focus of mental health services should be upon children and should be carried out in education rather than "treatment" methods.

The staffing pattern of the Multi-County Mental Health Center was chosen on the basis of our projected community programming. For the most part, staff members were selected by skills rather than discipline background. Psychological evaluation skills and medical expertise were the two exceptions to this general rule. Foreseeing close working relationships with clergy, education, medical and volunteer workers, we defined staff needs in terms of these target groups. The resulting staff backgrounds included medicine, psychology, education, social work and clinical chaplaincy. We have come to believe, moreover, that the most valuable person for a community mental health staff is an educator with mental health skills. Future staff expansion will no doubt entail the addition of educators more than the traditional mental health professions.

There are many ways in which mental health centers can work with local school systems. Once sanction is received from the proper persons in each organization, it is desirable that representatives of both mental health center and school system confer together to negotiate the types of services that shall be employed. We recommend a limited time period, such as 6 months, in which specific goals are set down by mutual consent of both organizations. This should be committed to writing and reviewed at the end of the pre-set period if not consistently throughout the period. It would be easy, of course, to become overly zealous about such a contract of operation, but there is no reason that an informal written agreement, perhaps in the form of a confirmation letter, could not serve the purpose of clarity without becoming unduly legalistic.

Proper sanction from superintendents and school boards and unmistakable clarity about mutual expectancies are critical matters. The obstacles to successful programming are often so subtle that every possible mechanism to "stack the cards" in favor of success must be employed. The potency of institutional inertia, jealousy over professional "territories," and tendency to produce innovation without real change cannot be overrated.

It is true that mental health people have been too timid about assertively changing what is expected of them. We have failed to state loudly that our time spent as testers and as therapists does not effectively attack the problems of human behavior that schools know only too well. But while we must be aggressive, we must address ourselves to the problems *as the educator sees them* if we are to gain entry to the classroom. We must lend our skills to the frustrations felt by teachers who are struck at every turn by behavior problems; we must help teachers find more joy in teaching; we must help reduce costs of teacher turnover brought about by too little training in the most challenging part of classroom management—behavior. We must in most ways be a helper to the school, not its conscience.

METHOD OF SERVICE DELIVERY

Most means of working with school systems fall into the consultation and education function of a mental health center. While we are only now coming around to some agreements on the meaning of these terms, consultation and education almost always suggest an indirect method of delivering services to the ultimate consumer. It is a system of backup, training, advice, or other sort of interaction which enables the recipient (consultee, trainee, client, peer-professional) to deal more effectively with the human behavior aspects of his own work with people.

Consultation as narrowly defined emphasizes the consultant's attempt to "release" the problem solving potential of the consultee. In other words, the consultee (classroom teacher, principal, etc.) has problem-solving skills which are not being maximized due to failures in communication, intrapersonal blocks, lack of confidence or other reasons. The role of the consultant is not to give advice nor impart knowledge, but to help the consultee more effectively tap his own ability to solve problems and to be more effective with his professional tasks.

Consultation of this sort can occur with a group or with individuals and might well be used with teachers, principals or others of the ad-

ministrative staff. Schools, like any other organizations in industry or commerce, encounter most of their difficulties in people problems rather than technology problems. Helping persons solve problems in this area is usually referred to as administrative consultation and aims at the more effective consideration of human processes and carrying out the organizational mission.

Teaching through case consultation often occurs along with consultation as more purely defined above. The mental health professional comes to the school with certain professional skills which might be profitably shared with the educator. A teacher, for example, who is encountering difficulties with a disturbed child might legitimately ask to discuss the child's behavior with a mental health person to gain skills with which the child might be more effectively handled. In this sort of case consultation, the consultant may or may not see the child, but will usually concentrate on enhancing the teacher's skill in dealing with behavior in the classroom. While this will be focally concerned with the child in question, there is far greater utility to be gained if the material is handled in such a way that the teacher can apply these new skills to all children in the classroom. The implications for prevention and early change of troublesome behavior are obvious. This sort of consultation should, of course, include follow-up visits by the consultant to make necessary adjustments in the advice given the teacher. Perhaps even more important, this assures the teacher that professional mental health backup is available should the teacher feel he has overextended his expertise.

We have found far greater utility in using this method of service delivery if we systematically take with us some central office person in the school system. Let me use as an example one school system with which we have worked. It employs an elementary guidance counselor whose job is to serve the guidance needs of six rural elementary schools. This counselor accompanied the mental health consultant on all consultative visits with teachers in the schools. Due to continual exposure to the application of mental health skills to specific child problems, the guidance counselor became increasingly proficient in teaching these skills to teachers on her own. She was able to apply this learning in such a way that her need for mental health consultation decreased monthly. While the consultant could only spend a few hours a week with the school system, the guidance counselor could spend 40. A practical skill had been transferred to a person in the school system who could use it effectively with many teachers.

An Example of Teaching Through Case Consultation is the case of fourth grade Cindy. She had been diagnosed as emotionally disturbed after extensive child psychiatric outpatient treatment, during which time little change had taken place. She was withdrawn at school, and often absent with very real symptoms of physical distress. School personnel and parents were confused, fearful, and uncertain as to what approaches might be helpful.

Cindy's parents had grown quite sensitive to her problems, but they tended to respond much more to her weaknesses than to her strengths. As a result, Cindy's most available route to gaining parental attention was through weak and inappropriate behavior. The school staff as well inadvertently reinforced Cindy's negative and manipulative actions and often let her have her own way. These responses by the parents and school were normal and understandable, but they nevertheless contributed unwittingly to Cindy's difficulties.

Cindy, her parents, and the elementary guidance teacher were seen one time by a mental health consultant on the Center staff. Subsequent work was done exclusively by the guidance teacher with periodic consultation to her from the consultant. She structured the parents' response to the child, set up a management plan with Cindy's teacher, set goals and limits, and even instructed the school bus driver. As a result of this diffused communication, Cindy was able to remain in her regular school classroom. Not all of her problems were solved, but positive behavioral changes did take place. The special persons in Cindy's life learned to respond to and reinforce her appropriate rather than inappropriate behavior. Moreover, learning through the clear success with Cindy has helped the guidance counselor to move effec-

tively with many other children, parents, and teachers.

Inservice training is no stranger to classroom teachers; it is a more formalized method of what usually is a didactic approach to training. We are somewhat biased toward teaching through a case consultation method rather than inservice. We have found that a given teacher who is particularly disturbed about her interaction with one child is more ready to learn than a teacher in the relatively sterile inservice training setting. Nonetheless, we do believe that inservice training for teachers can be a useful device to teach a number of skills to help teachers deal more effectively with childhood behavior. Demonstration and the use of video tapes can help overcome the sterile nature that often besets inservice training.

We are employing a hybrid of case consultation and inservice training started in the fall of 1970. Having felt that we often failed during the previous year to provide sufficiently intense input for lasting change in individual teachers, we decided to meet with the faculty of an elementary school one afternoon per week for 8 weeks with a package program of instruction and "homework" for the teachers. Repetitive sessions were designed to cover (a) behavior management, (b) learning disabilities, and (c) teacher-parent communications.

Classroom behavior management instruction and case consultation draw heavily on the very creditable methods of Dr. Charles Madsen and Dr. Clifford Madsen of Florida State University. Their concepts concerning the positive classroom, "catching the child being good,'" and other elements are easily adapted to class or home and represent an acceptable combination of behavior modification and human warmth.

One means of inservice training which we intend to employ is the regular seminar approach to training secondary school counselors. The seminars will attempt to make counselors more comfortable with disturbed behavior and more effective as behavior experts and counselors. It is our hope that schools can eventually see their counseling personnel as resident resource persons who can address themselves to the problems encountered by classroom teachers. It is unlikely, however, that school counselors will ever be viewed in this light by other teachers until they can demonstrate sufficient expertise to earn this respect.

Supervised practicum experience may be used to augment the special training of counselors or of any other teachers as shown below. Researh has indicated that well trained volunteers can be very productive counselors. For this reason and because of the necessity to multiply our manpower, we do not hesitate to involve volunteers and paraprofessionals as cotherapists in training. To provide the practical setting in which the previously discussed seminar training skills can be more firmly routed, we intend to involve school counselors as cotherapists whenever possible. This will give both substantive and face validity to legitimizing the school counselor as a resource to other teachers based on his demonstrated human behavior knowledge and training.

Personal growth groups. The current concern about drug abuse and other problems plaguing the late adolescent and young adult has led us to view with dismay our ineffective handling of these problems after they have become full-blown. We believe that aiding the secondary school teacher to become a better human resource to his students would be a far more effective way of decreasing the ills that plague young people than by exposing them to reams of data on drug use, alcoholism or other problem areas. To this end we have encouraged formation of personal growth groups in secondary schools which have as their purpose the enhancement of relating skills, use of one's peers as resources, and sharing common human problems, joys, and communication. These groups are open to all students, not just those labeled as troubled or delinquent. While a mental health staff member initiates all such groups, a faculty member is taken as a co-leader and learns after a number of weeks to take over the group leadership. The development of trust, empathy, communications uncluttered by "generation gap" lines, and a general feeling of personal resourcefulness and strength are the intended goals of such groups. We will only run these groups if teachers are willing to participate in training.

Growth groups are characteristically initiated by a presentation on mental health to an as-

sembled student body. Applications are taken from interested students. The groups are explained as an opportunity to know one's self better and to develop better relationships with others. Groups meet once weekly during school hours with a teacher and a Center staff member. Although classwork missed must be made up, groups are a legitimate excuse from class. This is meant to convey that the group is important enough to be offered during the school day so that bus riders, for example, are not penalized, but that it is not just a time to get out of class requirements.

In all these ways the schools with which we work are increasingly addressing themselves to the whole child.

CONTENT OF SERVICE DELIVERY

We have talked thus far about some of the methods used to deliver mental health services in the schools. It may be a separate issue to consider just what kind of service is conveyed. Pure consultation as defined above delivers a service aimed at enhancing the problem-solving skills and effectiveness of consultees. In the case of the other methods, however, a clear statement of what we see to be the most useful conceptualization of treatment and human behavior is in order.

With the exception of a portion of secondary guidance counselor training, it is not the intention of this program to make teachers into psychotherapists. It is our intention to present to school people a conceptual scheme wherein human behavior may be looked at in a relatively uncomplicated fashion, a way which by its nature suggests methods not only of understanding, but of *changing* behavior. More often than not this entails a learning rather than a psychoanalytic approach to child behavior.

The application of positive reinforcement techniques and the habit of looking at behavior as a learned phenomenon have extensive implications for classroom management and teacher satisfaction as well. This service from a mental health facility is meant to supplement what is provided in teacher training institutions.

In addition to the external contingencies affecting behavior, there is an internal set of factors which needs to be harnessed more productively. "Internal" is not meant to reintroduce psychodynamics, but to focus upon the child as a neurological unit of high integrity. Sequences of perception and motor development are critical to building concepts, reading and all academic skills. Overlooking the crippling effects of these developmental difficulties has led to the wasteful labeling of many children as retarded, dyslexic, unmotivated, disturbed, *ad infinitum*.

SUMMARY

The largest obstacle to working out more effective programs for the mental health of children are the problems of the service givers themselves. The defensiveness of teachers to outside help is matched by the defensiveness of mental health professionals. This defensiveness, of course, varies among individuals and is demonstrated in any number of ways. But perhaps the main way it is shown is a passive type of defiance by teachers and a presumptuous "expert" haughtiness of mental health people. These defenses sometimes obscure the fact that teachers feel the need for help in behavior management and the equally important fact that mental health professionals often feel out of their element and therefore somewhat unprepared in the school room. Far-reaching overhaul of existing systems will be necessary to make our efforts more than patchwork. But we must begin. Changes in our training institutions can certainly go far to correct this, but for those of us already in the field the best solution may lie in an increased attempt at tolerance and a joint commitment to the children whom we serve.

PART B: CHAPTER THREE

SUBURBAN SETTING

Mental Health Study Center, Adelphi, Maryland

A COLLABORATIVE PROGRAM OF MENTAL HEALTH AND EDUCATION IN RURAL AND SUBURBAN MARYLAND

Prince George's County, Beryce MacLennan, Ph.D.

SETTING

The school system in Prince George's County, Maryland, is a very large county system which in 1969 served approximately 145,000 children. In the southern part of the county, where this program has been operating for over 3 years, the region has a heterogeneous population and extremes of wealth and poverty. Housing ranges from substandard, without running water or indoor sanitation, to luxury. The far southeast section of the county is predominantly agricultural, with a large proportion of the population living as tenant farmers on large tobacco farms. As one approaches the District of Columbia, population density increases and many suburban developments and high rise apartments can be seen along access routes to the city.

HISTORY

The Mental Health Study Center, a research and demonstration arm of the National Institute of Mental Health located in Prince George's County, Md., had a history of consultation to the local school system prior to the programs reported here. School consultation was offered to pupil personnel workers, to special programs, and to a special school for organically handicapped children.

In 1967 the Study Center adopted the role of a Community Mental Health Center and concerned itself with the mental health of the broader community. The added responsibilities involved in becoming a Community Mental Health Center made apparent the need for a program which could not only meet specific crisis situations but also focus on the maintenance of mental health in the area and *prevention* of disturbance.

OBJECTIVES

It was anticipated that the program, through consultation, would:

1. Assist school staff members to understand the mental health climate, issues, problems and resources of the area, and to serve as a point of entry to the community.
2. Assist in identifying, referring, and treating children in need of specialized help, with help being given in the school setting whenever possible.
3. Assist in creating a positive mental health climate in the schools and in dealing with the everyday mental health experiences of the average child.
4. Promote cooperative exploration between the Center staff and schools into the question of how curriculums could promote the development of sound human relations among students.

To accomplish these goals the Center consultants would need access to various parts of the school system. The Center's new responsibilities had to be made known and services interpreted to the schools. Goals and priorities had to be established with the educational staff. The Center staff had to more clearly understand the internal structure and functioning of the schools. In addition, all community resources which might successfully collaborate in the program had to be assessed as to present and potential capacity for helping to create and maintain a sound mental health climate.

ACTION

The first step was to expand and capitalize on the friendly relationships with the school

system which had been established in previous years. In the summer of 1967, senior members of the Center met with the school superintendent, his deputy, and all of his program supervisors. Old acquaintances were revived and new ones made.

Center personnel explained their new responsibilities and described the services they hoped to offer. Education representatives presented their views on the school system and discussed the problems with which they wanted help. Goals held in common were clarified. The most effective patterns of collaborative effort were suggested and considered. The Center staff then began to meet with area supervisors, school administrators, teaching staff, and special school personnel, pursuing the same collaborative planning.

TEAM FORMATION

The Center staff divided into geographically identifiable sub-area teams to more clearly understand the varied neighborhoods and their widely differing needs and resources. The teams were given considerable latitude in the development of their activities, deciding how they would combine consultation, inservice training, and education with direct outpatient service. In the first year all the teams met with the pupil personnel workers and psychologists serving their area. Overlapping roles and functions were disclosed, and the consultants gained a better understanding of the strengths and weaknesses of individual schools. This was important, since school psychologists had begun to include some mental health consultation and individual and group treatment in certain schools. Pupil personnel workers, in some instances, introduced the consultants to their schools and interpreted school problems to the Center staff. In most instances, however, the consultants approached the principals directly and made the first efforts toward collaboration through them.

Team I. Team I consisted of a child psychiatrist, a social worker, a psychiatric nurse, an adult psychiatrist, and a third psychiatrist who worked 2 days weekly. The sub-area they served contained a rapidly developing rural suburb and a large, sparsely populated farming territory. The population consisted primarily of middle class white and black groups, many transient armed service families, and poverty pockets filled with black and white agricultural and construction workers. The schools included several elementary, but only one junior and one senior high school. The team decided to focus on the two secondary schools and one elementary school located nearby, thus attempting concentrated rather than diffused service. Consultation was also offered to a grades 1-8 parochial school and a school serving organically and emotionally handicapped children.

Team I's major focus was on improving the emotional climate of the schools. Consultation aimed at increasing the sophistication and skills of the staff in working with children and parents, and in introducing programs into the curriculum to increase the capacity of the children and their parents to develop good human relations.

A psychiatrist and a social worker worked together in the secondary schools and one team member was assigned to each of the others—elementary, parochial, and special school.

The psychiatrist operating in the secondary schools met weekly with the principal, joined in administrative conferences, taught a course on human relations and family life, and assisted in the establishment of an after-school ad hoc committee of students and faculty to deal with a problem of race relations.

The social worker, a group-work specialist, trained staff members to use group methods. He demonstrated group counseling, group techniques in speech and reading classes, and group discussion for parents of children in special education. He also conducted a supportive group for beginning teachers. At the senior high school he assisted the psychology teacher in developing an after-school club for teenagers in which discussion of personal problems increased insights into human relations.

The consultant at the public elementary school, a psychiatric nurse, combined consultation with training and direct service. She observed classrooms before participating in conferences designed to assist staff members in identifying, clarifying, and designing suitable approaches to child problems. She collaborated in treatment of particularly difficult children and, in

some cases, joined in parent interviews. She developed a general human relations and child development training program for the faculty and participated in a PTA program relating school consultation to the national mental health movement.

Parochial school consultation offered different challenges. Since the school had no special services personnel, the consultant worked directly with the principal and faculty. Classes were larger, discipline was stricter, and the climate was more authoritarian. Problem students presented symptoms of severe disturbance, social withdrawal, or learning disabilities, but few behavioral difficulties. An eighth grade sex education course was started by this consultant and expanded the next year by another into a composite sex education, family living, and human relations laboratory. An attempt to train a faculty member to teach this course uncovered a conflict in role perception which may occur when the demands of advances in education place faculty in culturally inconsistent positions.

At the special school, half of which is devoted to orthopedically or neurologically handicapped children, the consultant's efforts were directed mainly toward the teachers' problems with acceptance of the disabled. Anxieties or rejections articulated and dealt with through consultation became less likely to interfere with progress of children in the classroom.

To extend a degree of service to those elementary schools in which consultation was not active, Team I held regular meetings with pupil personnel workers and psychologists from all the sub-area schools. Specific cases were discussed. Some were accepted for evaluation or brief intervention, and a broad range of topics was explored. These included management of suicide threats, significance of homosexual behavior, school and board of education politics, family problems, classroom techniques, and other issues concerning child development.

Team II. Team II consisted of one adult psychiatrist, one child psychiatrist, one psychiatric nurse, and one part-time physician. The subarea they served was urban, rapidly expanding into suburbs. Housing was mainly high-rise or garden apartment sub-developments off high-speed highways. The population of approximately 50,000 was served by a very large shopping center where Team II was housed.

The three senior high, five junior high, and 18 elementary schools were overwhelmed by the sudden population increase. New schools in construction could not hope to cope with the headlong growth of the school-age population projected by the high percentage of young families. In response to the crushing demand for service, the system was redirecting the efforts of pupil personnel workers and psychologists by placing emphasis on consultation rather than on testing and crisis intervention.

During the first year, Team II planned a program to disperse its manpower in three carefully selected levels of the system:

1. Work with the pupil personnel workers and psychologists for more rapid and effective diagnosis and treatment of children with identified emotional problems.
2. Work with the 26 principals in group meetings, to help them develop methods of working with faculties to raise the level of mental health knowledge among them.
3. Work with teachers and other staff members in school conferences, utilizing specific cases to help them with classroom management and the handling of emotional problems.

The child psychiatrist helped an elementary school staff to successfully maintain, in the school setting, seriously disturbed children who had been referred for residential treatment. The children spent 1 hour daily with a teacher in their own special class. The consultant met weekly with this teacher and all others working with the children to analyze the problems of both children and staff. The understandings gained by the teachers were carried over into other situations, and the children involved remained in the school.

On all three levels, consultation broadened the range and impact of mental health skills, and the team members learned a great deal about the interpersonal patterns among school staff and students. However, team members felt that their efforts were spread too broadly for maximum impact. Consequently, during the second year, Team II decided to refocus its efforts on what it saw as the community's major problem to be approached through mental health education coordination—the problems of adoles-

cence. After exploratory meetings with various agencies dealing with adolescents, the team decided to concentrate on working with one senior high school.

With the principal's cooperation, regular meetings were held with a group of teachers, and a questionnaire to survey adolescent needs was designed and distributed to the students. Among the 24 questions for anonymous response were a number relating to the students' attitudes toward school personnel and authority figures, personal problems, and hopes or desires for change in life situations. In conjunction with this questionnaire, the team worked with the school in developing a course in crisis management for all personnel and later repeated this training course in other schools.

Team III. Team III consisted of three psychiatrists and one mental health nurse. At the start of the program, two of the psychiatrists were new to the area and knew little about the Team's sub-area except its geographical boundaries.

The sub-area included over half of the catchment population—110,000 people. Within it were small Negro ghetto communities of blatant poverty, communities in transition where middle class Negroes leaving the city were displacing white lower-middle class groups, and an Air Force base with an overwhelmingly white, middle class population. The 27 schools scattered in this area were correspondingly dissimilar, and the communities and problems were too diversified to allow for a unified approach by a team of four people.

The first task was to decide on the point and method of entry. A Center social scientist who had done a participant observation study in the poverty area offered to introduce the Team to the community leaders. The Team's chief was interested in working with ghetto residents in mental health activities. The poverty area became, therefore, the chosen point of entry. Major emphasis was placed on a two-point program:

1. Establishment of a walk-in clinic to provide direct service, with an emphasis on evaluation and training of community action volunteers as mental health workers.
2. Efforts to make effective contacts as mental health workers.

Until the second year, therefore, Team III did not work as intensively within the schools as did its counterparts. However, the Board of Education was one of the first agencies approached and a meeting was held with the pupil services personnel working in the same area. At this meeting, one psychiatric consultant arranged a schedule whereby he met with each of eight pupil personnel workers once a month for individual consultation. In many instances, he accepted the child presented for evaluation at the walk-in clinic, school, or the Center. A few children were continued in individual or group treatment.

A second psychiatrist, called to an elementary school in a crisis situation, used this introduction as the basis for involvement with the whole school. He provided regular consultation to the school personnel and set up as a training demonstration an activity group for latency-age boys who had been presenting problems.

A third psychiatrist and the psychiatric nurse entered the elementary schools through the area supervisors. They worked with specific problems and provided consultation for teachers on classroom management. All Team members worked with the PTA's in developing programs related to mental health, thus informing and educating the area adults.

During the next 2 years much more intensive consultation was requested by one junior and one senior high school in the poverty area. Group counseling and special classes were provided for boys entering high school and identified as having serious emotional, behavioral, or learning problems. Consultation and training were given to teachers and counselors working with these boys. Consultation was also provided to the principals on the management of crises in these schools. Team III's approach in this difficult setting illustrates the pragmatic manner in which responses to a system's needs may lead to effective cooperation between mental health and education.

Team IV. Team IV, consisting of two psychiatrists and a psychiatric social worker, was developed during the program's second year to serve the southern fringe of the county—the largest, most undeveloped, and most sparsely populated sub-area. The general economic level

was low, with many tenant farmers living well below the poverty line.

Team IV began its field operations with an intensive survey of existing community resources. It was apparent that a major problem for the inhabitants—inadequate transportation facilities—was also a major obstacle to delivery of services. A second observation was that the Team's acceptance by the community was largely dependent upon its direct treatment services to the community.

The Team met with school administrators, general practitioners, public health nurses, members of the clergy, the local Health Council (a voluntary association), the Family Service Association, the State Police, the Mental Health Association, and a number of individual citizens interested in community affairs. From this exploration emerged the decision to concentrate activities in the public school system, the one institution reaching into almost every home in the area.

Most of the first year was spent establishing consultation programs in the schools. One psychiatrist worked with a junior and a senior high school, consulting with the guidance counselors, the principal, and the teachers. This consultation centered on problem cases and on administrative and organizational difficulties. Later, identification of potential school drop-outs and prevention of disorders became major concerns.

The second psychiatrist, at a junior high school, provided direct treatment to difficult adolescents and used these cases as training situations for the counselors. He and a counselor formed a group for several girls who were causing disturbances to themselves and others.

The social worker met with the principals of the six elementary schools, and a regular consultation program was developed in four of the schools. The reactions of the principals varied and the process of negotiation had a different course in each school. In one school, the consultant was immediately welcomed and the principle attempted to involve all her staff in the new activity. In a second, the principal was not sure that he wanted consultation. He met with the consultant for several months, gradually gaining confidence in her before he revealed to her any of the problems in his school. A third principal demonstrated that he did not wish outside consultation by cancelling all appointments which were set up with him. In most schools here, as in the other Team areas, the consultant-consultee relationship took time and effort to develop.

For direct service, two walk-in clinics located in the school buildings were established. The social worker screened students and coordinated activities one-half day per week, and one of the psychiatrists was available for direct treatment in each clinic for the same amount of time. Gradually, however, since there was little utilization of this service, the clinics became referral centers. A valuable by-product emerged from one clinic experience—a very effective consultation relationship with the principal, from whom the psychiatrist had to get the clinic key on each visit. A training program in human relations for the teachers resulted from this relationship, at the principal's request.

INTERVENTION IN A COMMUNITY CRISIS

In the area serviced by Team III, there were only two remaining all black secondary schools: a junior and a senior high. These schools became part of a controversial desegregation plan involving eight secondary schools in the system.

Feelings about race relations became heightened and there was an urgent demand for assistance with students, staff, and community. The atmosphere was one of imminent crisis and required quick and concerted action by all the Center teams. Two consultants worked with an inservice training institute at one of the elementary schools. Six members of the staff took part in a student-faculty-community intensive planning workshop for desegregation of the secondary schools.

The program's coordinator worked with the desegregation project coordinator and the workshop planners, consulted with the School Board and superintendent, and participated in the superintendent's faculty-community advisory committee. This consultant also helped to develop a coalition of community groups which worked to organize community leaders, residents, and parents to support a smooth school transition. Meetings of teachers, parents, and interracial groups of students were organized.

A short seminar for teachers in conjunction with the university on intergroup problems in the classroom was provided.

Many underlying discontents in regard to interpersonal relationships within the schools were brought to the surface and dealt with during this crisis. The Center staff was able to assist more effectively with these disturbances, then and later, because it already had an understanding of the school system and a sound working relationship with many school personnel.

Although the Center staff was consulted on issues pertaining to the management of special problems within the system throughout its history of working with the schools, it was not until the desegregation crisis that consultation was requested on matters pertaining to the management and climate of the system as a whole. However, without their extensive knowledge of the place and people, it seems doubtful that the Center staff could have given much effective assistance, or even been consulted at all.

EVALUATION

Methods for evaluating the program's impact are still very primitive, but from the start the Center has attempted to gather some information on progress by:

1. A system for recording all contracts and activities for the consultation itself and any children considered in it.
2. A weekly workshop for program review.
3. Regular consultants' review and evaluation of consultation with consultees.
4. Annual program evaluation between the Center staff and school administrators.
5. Written request at end of first year for assessment of the service by all consultees.
6. Reactions of all pupil personnel workers obtained at end of second year.
7. A study of 111 children in case consultation to evaluate follow-through on consultation plans and effectiveness.
8. The attempt to design in the third year, specific projects with more concrete evaluation built in.

The overall staff evaluation, referring to stated goals, agreed that:

1. The staff obtained a good understanding of the school system, its functioning, strengths, and stresses.
2. Good working relationships were established with the superintendent and several of his key administrators.
3. Consultation was requested and provided extensively on special problems within the system.
4. Consultation on management and climate of the system was requested and provided at a time of community crisis.
5. Intensive consultation was offered to four senior high, two junior high and 33 elementary schools and principals, and consultation and training was provided to all the psychologists, pupil personnel workers, and a large percentage of the counselors and teachers in the area.
6. The staff had direct contact with students and parents through mental health education and treatment, and through contact with the PTA's.
7. The staff had limited influence on classroom climate and curriculum through staff teaching, classes, and extracurricular activities in which they were involved. Some of the special demonstrations have been incorporated into school practice.

CONCLUSION

The Mental Health Center staff cannot overemphasize the importance of the establishment of good relations, with mutual respect for each other's disciplines and a minimum of jargon, between school and Center.

Some teachers suffer from loneliness, feelings of inadequacy, and problems of communication which impair their efforts at helping children. Sorely needed is teacher training in human relations, group processes, and the management of everyday problems in the classroom.

Students, we have found, long for more relevant school experiences. They want schools that are geared to their personal needs—schools where they are respected, where they are taught to have inquiring, problem-solving attitudes toward life, and where they are helped to develop satisfying human relationships.

The Community Mental Health Center can significantly and positively affect the future mental health of youth—if it works with the schools, preferably *in* the schools, and is allowed to develop long-range programs.

APPENDICES

APPENDIX I

Additional CMHC-School Mental Health Programs

County of Santa Clara Community Mental Health Center, San Jose, California

The county school superintendent's office has assigned six school counselors to the Mental Health Center for a period of 6 weeks each. They will participate in all activities of the Center, e.g. participate as members of the multidisciplinary teams of the Center's 24-hour emergency and walk-in service, as group co-leaders in outpatient services, in the drug abuse and alcoholism programs, etc. They receive 6 hours credit from a local state college for the time spent.

Two "mini-centers" located directly in schools were established so that problems could be handled immediately within the school setting, and so school personnel could observe mental health professionals in action and gain a better understanding of ways of dealing with children's learning and behavioral problems.

Kennedy Child Study Center, Santa Monica, California

A special priority clinic has been set up to assist families with children who have been threatened with expulsion from school. This service allows children to remain in school while being assisted.

Denver Community Mental Health Center, Denver, Colorado

The Center assists a school program of educational evaluation and remediation. This includes planning with teachers and other school personnel for modification of a child's educational program when he is not succeeding in the regular class, and supervising volunteer tutors who can follow the remedial prescription either at school or at the clinic.

The Center sponsors an educational lab program and a crisis room program which attempt to modify behavior by personalizing learning. The programs include classroom observations, in-classroom consultation, development of individualized educational prescriptions, and consultation to teachers re: group techniques applied to the classroom setting.

Jefferson County Mental Health Center, Denver and Lakewood, Colorado

A joint venture between the Jefferson County School District and the Community Mental Health Center has resulted in the establishment of a school for children who are so emotionally disturbed that they cannot be taught in a regular classroom, yet who do not require placement in a residential facility. Goal —to return children to the regular classroom within 2 years with appropriate followup. The school is staffed with both mental health and education personnel.

Community Mental Health Center, Pensacola, Florida

The Center's program includes projects in precision teaching and precise behavior management.

Institute for Juvenile Research, Community Mental Health Center, Chicago, Illinois

Teachers are trained by the Center in behavior modification techniques which will enable them to manage moderate to severe individual and group classroom behavior problems.

Training and supervision is provided to eighth grade students to enable them to tutor second grade students in English and reading. Tutors participate in weekly sessions focused on learning, tutoring techniques and self-confidence instilling techniques.

Comprehensive Community Mental Health Center of Rock Island and Mercer Counties, Illinois

The Center will provide a 12-week course, 3 hours per week to assist teachers in better understanding learning theory and its application to the classroom setting.

Prairie View Community Mental Health Center, Newton, Kansas

The Center sponsors monthly consultation lunches for elementary school principals, secondary school principals and guidance counselors. Consideration is given to mental health related problems arising in the school setting. Topics of these luncheon sessions include behavioral problems of students, drug abuse education, teacher evaluation, communication among school personnel, parent conferences, classroom management, and curricula changes.

Appalachian Comprehensive Community Mental Health Center, Ashland, Kentucky

The Center offers a 10 lecture mental health course for high school students. Some of the objectives are:

- to understand underlying causes of behavior.
- to become aware that different causes may be behind the same behavior in different persons and that the same causes may produce different reactions in different people.
- to make consistent attempts to see things from the viewpoint of others.
- to realize the effects one's behavior may have on the behavior of others.
- to understand the relationship of mental and physical health to success or failure in school.

The Counseling Center Community Mental Health Center, Bangor, Maine

The Center sponsors an inservice training "Mental Health Course for School Personnel" which can be used for certification credit by teachers.

A special unit of the Center—the School Service Unit—provides crisis intervention help for problem children to prevent them from reaching more serious stages of emotional disturbance.

Boston University School of Medicine Community Mental Health Center, Boston, Massachusetts

A joint committee of persons from the Division of Psychiatry and the School of Education of Boston University planned, with the representatives of the school system, a class in an inner city school for five to 10 children excluded or about to be excluded from public schools in the catchment area. The school system provided space and a salary for a special teacher; the School of Education provided special education consultation and graduate student input; the Mental Health Center provided mental health consultation and support.

Regional Mental Health Complex Community Mental Health Center, Tupelo, Mississippi

The Center provided a 2-day inservice education institute on classroom adjustment and management problems for elementary teachers and other professional workers. Institute workshop included case presentations, reports, small group discussions, films, and lectures.

East Central Missouri Mental Health Center, Mexico, Missouri

The Center is in the process of helping one particular school system within its catchment area to restructure its public school philosophy along the lines of that explained in William Glasser's *Schools Without Failure*. Some of the areas of discussion with this particular school system are whether or not competition among children is healthy, the value of offering grades, why kids sit in rows rather than making the classroom informal, and offering a more democratic student participation program.

Malcolm Bliss Community Mental Health Center, St. Louis, Missouri

The Center has developed a series of 16 video taped television programs, together with a teachers' guide for teachers within the St. Louis metropolitan area. The purpose is to help teachers recognize and cope with mild, moderate, and severe learning and behavioral difficulties in children. The series includes input from psychiatrists, psychologists, social workers, special educators, and regular classroom teachers. It is directed toward helping teachers better understand how to handle problems in the classroom and how to recognize problems that need to be referred to a specialist.

Darmouth-Hitchcock Community Mental Health Center, Hanover, New Hampshire

An important part of the Center's program is the "Psychoeducational Evaluation Program"—to study children's developmental and adjustment problems in the areas of perception, cognition, feeling, behavior, and to devise practical ways of fostering growth where deficiencies exist. The program is also developing a teaching program for professionals in the fields of education and mental health.

Sound View-Throgs Neck Community Mental Health Center, Bronx, New York

The Center offered a three credit "In-Service Course on Group Dynamics and Process" (under the aegis of the Board of Education)—a human relations course for teachers and guidance counselors aimed at improving interpersonal skills, personal relations, and effectiveness in working with groups and organizations.

Other programs include:

- *Organizational Development Program*—intensive work with three school principals. Through group and individual consultation, everyday problems were utilized as the vehicle through which the principals could develop skills in problem-solving and effective decision making, and develop new styles of leadership.
- *Guided Group Interaction Program* – for the small percentage of disruptive delinquent youth in school. Guided Group Interaction calls upon the tremendous, often untapped, human resource in the youth themselves—it uses peer influence to get members to think and do what is wanted. Focus of program is to establish positive social norms that are relevant to these students.
- Forum in School-Community Relations — During the New York City school strike, staff members of the Community Mental Health Center, along with local community members, helped

plan and execute a forum in school-community relations. It was felt that the Forum would provide an opportunity for all factions to have their positions heard by others in an atmosphere of reason rather than in one of passion which prevailed at the time. Those who participated in the Forum (over 130 parents, teachers, students, principals, and district administrators) felt it was a small example of how people could work together cooperatively even in chaotic times. The Center has since received several requests from parent associations to help them organize similar types of workshops.

Further suggestions:

- Have Center consultants work with grass roots community groups and PTAs as well as with schools per se. Consultee should be the school-community system rather than just the school
- Have people from school-community system on Center Advisory Boards, i.e. a school principal might become a member of the Center advisory board.
- Have Center train community residents and school personnel during summer months.
- Open up field placements for education students in Mental Health Centers.

Convalescent Hospital for Children, Community Mental Health Center, Rochester, New York

The Center sponsors:

- primary teacher consultation groups.
- "personalized approach to learning"—a specialized educational program for students who have not adjusted to the academic and institutional requirements of the school system.
- early detection and remediation of learning disabilities. All teachers involved in this program meet regularly with the consultant. The sessions attempt to help the teacher better understand, deal with, and accept the broad range of pupil types in his classroom.
- program to enhance the skills of guidance counselors. The mental health consultant leads a case oriented discussion group for guidance counselors concerned with therapeutically relating to parents and students.
- program to train guidance counselors to serve as mental health consultants for groups of primary school teachers.
- mental health consultation to a day care and child care center.

Rochester Mental Health Center, Rochester, New York

The Center is involved in a clinical teacher training project for the educational improvement of emotionally handicapped children. Training includes monitored observations through one-way viewing screens at the Mental Health Center, didactic discussions, seminars on behavior modification principles, and analysis of video taped sessions demonstrating teaching strategies. Methods are taught through the use of micro teaching, sociodrama and role playing.

W. H. Trentman Mental Health Center, Raleigh, North Carolina

The Center provides part-time placement of psychology students and social work students in school settings.

The Center conducts workshops for teachers, counselors, and principals regarding "mental health in the classroom."

Falls View Mental Health Center, Cuyahoga Falls, Ohio

The Center sponsors a "Youth Services Program" designed to prevent hospitalization by treating adolescents on an out-patient basis before they need hospitalization.

Central State Community Mental Health Center, Norman, Oklahoma

The Center provides consultation to a school drug education program and sponsors a "Pre-Drop Out" student volunteer program.

Thomas Jefferson University, Community Mental Health-Mental Retardation Center, Philadelphia, Pennsylvania

The Center conducts staff development seminars for school personnel, using interaction analysis and microteaching techniques. Interaction analysis is a tool for helping teachers conceptualize teaching in terms of the actual behaviors they perform in the classroom and the kinds of student behaviors they engender. Microteaching is designed to be a non-threatening laboratory situation in which teachers can receive feedback about their teaching strengths and weaknesses and also practice specific teaching skills.

Hahnemann Community Mental Health and Retardation Center, Philadelphia, Pennsylvania

The philosophy underlying the Center's activities with the schools is one of helping the *system* to change in such a fashion as to make it more responsive to the broad needs of children. Mental health staff conduct a workshop, "Children's Classroom Behaviors—their Implications for Teaching Strategies." The primary focus of mental health consultation is to keep the problem child in the classroom and to assist the teacher in finding solutions to his problems within the classroom setting.

Pennsylvania Hospital Community Mental Health Center, Philadelphia, Pennsylvania

A special Unit (composed of six mental health professionals) of the Center was designated to facilitate changes in the educational institutions, system,

and structure. The university's role was defined as attempting to identify, within the child's school experience, those psychological components which have a lasting impact on the developmental growth process, particularly those related to ego functioning. *Prevention* of disabilities and enhancing of social competence of students and school personnel become the Unit's goal.

An extension of the concept of primary prevention is to assist schools in developing the capacity to become their own resource.

Consultation to help individual teachers develop strategies and programs for working with problem children, working with team teaching leaders to develop their group leadership skills, and providing a group experience for some of the staff interested in examining in-school working relationships.

Community Mental Health Center, St. Francis General Hospital, Pittsburgh, Pennsylvania

The Center has developed a "Quiet Room" project—rationale—children who have temporary emotional upsets which prevent them from functioning in school are frequently viewed as disciplinary problems and handled through disciplinary channels —i.e., being sent to the principal's office, made to return after school, etc. Goal of this project is to provide an alternative to this disciplinary procedure wherein the child can withdraw from the classroom, have an opportunity to come to grips with his emotional state, resolve it, and return to class. Groups of volunteer parents are trained by Mental Health Center staff re: child development theory, counseling techniques, utilization of play materials, etc. These persons rotate in manning the "quiet room."

APPENDIX II

Selected References

1. Association of State and Territorial Health Officers, Association of State and Territorial Mental Health Authorities and Council of Chief State School Officers. *Mental Health in the Schools*. Washington, D.C., 1966.
2. Berlin, I. N. Mental Health Consultation in Schools as a Means of Communicating Mental Health Principles. *Journal of the American Academy of Child Psychiatry*. 1, 4: 671–679, 1962.
3. Caplan, G. *The Theory and Practice of Mental Health Consultation*. New York: Basic Books, 1970.
4. D'Evelyn, Katherine E. *Developing Mentally Healthy Children*. Study/Action Publication from the American Association of Elementary-Kindergarten-Nursery Educators, National Education Association Center. Washington, D.C., 1970.
5. Glasser, William G. *Schools Without Failure*. New York City: Harper & Row, 1969.
6. Goldston, S. E. Mental Health Education in a Community Mental Health Center. *American Journal of Public Health*. 58, 4: 693–699, 1968.
7. Hogg Foundation for Mental Health, University of Texas. *Principles and School Practices*. Austin, Texas, 1965, 10c.
8. Hollister, William G., M.D. *Program Ideas on Mental Health*. Chicago: National Congress of Parents and Teachers, 1968.
9. Holt, John. *How Children Fail*. New York: Pitman, 1964.
10. Iscoe, I., Pierce-Jones, J., Friedman, S. T., and McGehearty, L. Some Strategies in Mental Health Consultation: A Brief Description of a Project and Some Preliminary Results. In E. L. Cowen, E. A. Gardner and M. Zax (Eds.), *Emergent Approaches to Mental Health Problems*. New York: Appleton-Century-Crofts, 1967, 307–330.
11. Jersild, A. T. *When Teachers Face Themselves*. New York: New York Teachers College, Columbia University, 1955.
12. Levenson, A. I., and Brown, B. Social Implications of the Community Mental Health Center Concept. In J. Zubin and F. A. Freyhan (Eds.), *Social Psychiatry*. New York: Grune & Stratton, 1968, 117–127.
13. MacLennan, Beryce W., Montgomery, Shirley L. and Stern, Etta G. *The Analysis and Evaluation of the Consultation Component in a Community Mental Health Center*. Laboratory Paper No. 36, Mental Health Study Center, Adelphi, Maryland, NIMH, July, 1970.
14. Mannino, F. V. *Consultation in Mental Health and Related Fields. A Reference Guide*. Chevy Chase, Maryland, NIMH, 1969.
15. Mid-continent Regional Educational Laboratory. *Now I Have Known Me*, a Mental Health Monograph. Vol. 1, #4: Spring, 1970.
16. National Education Association. *Learning and Mental Health in the Schools*. Washington, D.C.: Yearbook, 1966.
17. National Education Association. *Perceiving, Behaving, Becoming*. Washington, D.C.: Yearbook, 1962.
18. Newman, R. G. *Psychological Consultation in the Schools*. New York: Basic Books, 1967.

19. Ojemann, Ralph H. *Personality Adjustment of Individual Children.* Washington, D.C.: Association of Classroom Teachers of the National Education Association, 1969.
20. Prouty, Robert W., and Prillaman, Douglas Diagnostic Teaching: A Modest Proposal. *Elementary School Journal.* Vol. 70, No. 5: 265–270, Feb., 1970.
21. Seashore, C., and Van Egmond, E. The Consultant-Trainer Role in Working Directly with a Total Staff. *Journal of Social Issues.* 15, 2: 43–50, 1959.
22. U.S. Dept. HEW Annotated Bibliography on In-service Training for Allied Professionals and Non-Professionals in Community Mental Health, Public Health Service Publication No. 1901, Washington, D.C., U.S. Govt. Printing Office, 1969.
23. U.S. Dept. HEW. Selected Sources of Inexpensive Mental Health Materials. Public Health Service Publication No. 1911, Washington, D.C., U.S. Govt. Printing Office, 1968.
24. U.S. Dept. HEW. Mental Health Consultation to Programs for Children: A Review of Data Collected from Selected U.S. Sites, Public Health Service Publication No. 2066, Washington, D.C., U.S. Govt. Printing Office, 1970.
25. U.S. Dept. HEW. The Scope of Community Health Consultation and Education. Public Health Service Publication No. 2169, NIMH, Washington, D.C., U.S. Govt. Printing Office, 1971, 25c.

APPENDIX III

Authors' Acknowledgments

Maimonides Community Mental Health Center, Brooklyn, New York

Directly involved in the planning and implementation of the collaborative program from the Maimonides Community Mental Health Center have been Dr. Montague Ullman, the Director, and its Learning Rehabilitation Team, including Dr. Cecelia Pollack, former Director of Learning Rehabilitation Services, and the Learning Rehabilitation staff—Joseph Nahem, Patrick Lane, Ruth Atkins, Jean Cortopassi, Betty Hull, Ingrid Olsson, Adde Levine.

Key leaders from the local schools involved in the collaboration are:

District Bureau of Attendance: Arthur Clinton, Director

Team Leader: Marvin Nevid

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Previous Superintendent: Mr. John W. McCarthy

P. S. 1: Mr. David R. Ellison

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J.H.S. 136: Mrs. Gida Cavicchia

Reading Coordinator: Florence Ward

Bureau of Educational and Vocational Guidance: Eleanor S. Weingast

DISTRICT 20

Present Superintendent: Dr. Juliet Saunders

Previous Superintendent: Mr. Cornelius J. McQuillen

Reading Coordinator: Margery Hopkins

Bureau of Educational & Vocational Guidance: Joan Kip

Primary Mental Health Project, Rochester, N.Y.

The work reported in the present chapter was made possible by grants from NIMH Experimental and Special Training Branch (MH 11820–01–02), Monroe County Youth Board, N.Y. State Division of Urban Education. This support is greatly appreciated. The project could not have developed without the wholehearted cooperation of the school districts of Rochester, Fairport, Rush-Henrietta and West Irondequoit, N.Y. Core project staff include Darwin A. Dorr, Research Coordinator; Mary Ann Trost, Chief Social Worker; Louis D. Izzo, Chief Psychologist; Angelo Madonia, Consulting Psychiatrist; and Ruth V. Isaacson, Community Liaison Representative. The work described herein is the joint effort of all the groups and individuals, cited, with critical support from an active dedicated citizens' group, Primary Mental Health Project, Inc.

Range Mental Health Center, Virginia, Minnesota

Grateful appreciation is extended for cooperation from the 15 school districts in the Range area.

Multi-County Mental Health Center, Tullahoma, Tennessee

Superintendents of area school systems are due appreciation for their cooperation. They were Messrs. Ralph Askins, Ted Beach, Don Bobo, James Cortner, Guy Ervin, James Jarrell, William Konnert, Fred Langford, Tom Towry, and Max Vann. Other school

personnel who played key roles in the program development included Fern Becker, Louise Dement, Shan Kelso, Ruth Luckado, Don McAllister, Mary McCreary, and Kathleen Smith.

Mental Health Study Center, Adelphi, Maryland

The following staff members assisted in planning and carrying out the school/mental health collaborative program:

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Spencer Ward, M.D.
Gustav Weiland, M.D.
Irene Zyniewicz, M.P.N.

It is impossible to mention by name all the school personnel who were so helpful to us in this program. We want particularly to thank a few key leaders from the Prince George's County School system who made it possible for us to gain access to their programs:

Present Superintendent of Schools: Dr. Carl Hassel

Previous Superintendent: Dr. William S. Schmidt

OMA: Jack Lynch, Margaret Conant

Director Pupil Personnel Workers: Marion Lobdell

Guidance Department: Katherine Rahannock

Special Education: Betty Reig, Frances Fuchs

Secondary School Principals: William Chestnut, James Gholston, Allen Fortune
R. Francis Eigenbrode, Richard Kaheer

Director, Pupil Services: Annabelle Ferguson

Director of Instruction: Gilbert Schiffman

and all the elementary school principals who shared their experiences with us.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1972 O—469-750